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ABSTRACT

This report of Colorado's 1987 Migrant Education Health Program details activities under the program, a cooperative undertaking by the state Health and Education departments. The report was written to provide: (1) assurance that the program's services have been within the scope and financial estimates of the interagency agreement; (2) a body of information for Migrant Education staff and parents concerning the relative health status and needs of Colorado's migrant children; and (3) planning assistance for the 1988 Migrant Education Health Program. This document includes statistics about the relative health of state migrant students and discusses the roles played by community and staff, including 21 health professional students and interns. This document details the health of the migrant students, including statistics on height, weight, hearing, vision, dental health, blood pressures, blood tests, skin tests, and scoliosis. Health education class activities are explained and attendance figures offered. An overview of the 1987 budget is included. A section on "Preparing for 1988" looks specifically into the areas of health education needs, the use of volunteers, and a summer "Life Choices" health and values education program. The second half of this document is a Migrant Education Health program grant proposal for 1988 operations. The proposal reviews the 1987 program and offers some 1988 goals. It proposes a continuation of medical screening, case management, dental services, and health education services. It explains the 1988 program budget, proposed staffing patterns for 13 locations and the role responsibilities for various departments and staff members. This document includes 39 graphs and tables. (TES)

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INTRODUCTION

For the past fifteen years the Colorado Migrant Health Program and the Colorado Migrant Education Program have worked cooperatively to provide comprehensive health services to students enrolled in Migrant Summer Schools. Over this period of time a set of agreements have evolved that promote smooth working relationships between two migrant program thrusts: Education and Health Services. The following two documents are presented here in order to describe both the outcome of our efforts and the approach we take to operationalize a coordinated effort between the Colorado Department of Education and the Colorado Department of Health.

Colorado is somewhat unique in that working agreements may be established at the state level because of the existence of a state-wide Migrant Health Program. We believe that most of what is presented here is useful regardless of scale. The approach and programmatic elements are similar whether there is a statewide program serving 2,000 students in twelve sites or a local program serving 150 students in one site. Particular attention should be focused on both the role responsibility and job description sections in the second document.

It is our hope that by sharing the nuts and bolts of Colorado's collaborative efforts we will encourage other Migrant Health and Migrant Education providers to work together on behalf of our mutual target population. Given the economic realities of the next few years, working together will become a practical necessity if we are to provide services in a cost-effective manner. Given our common aspirations for migrant children, working together will become an ethical imperative.

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FINAL REPORT

MIGRANT EDUCATION HEALTH PROGRAM

- 1987 -

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INTRODUCTION

1987 marks the 15th consecutive year that the Colorado Migrant Education Program and the Colorado Migrant Health Program have collaborated in the planning and implementation of a comprehensive health program for migrant summer school students. This collaboration has continually increased over the past several years as both programs have grown to appreciate that regardless of administrative affiliation, funding resources, or individual organizational objectives, both programs share a common mission: to participate in enhancing the physical, mental, social and economic well-being of migrant farmworkers. Both programs acknowledge that this mission requires a major focus on migrant children.

Not only do children of migrant farmworkers face the typical diseases and health problems of childhood but, in addition, they confront numerous health problems and risks associated with their migratory lifestyle and the environmental hazards associated with agricultural work. They also face numerous social, cultural and linguistic barriers which often preclude their ability to access regular, comprehensive health care. It is clear that maximum educational achievement may be hindered by undiagnosed and untreated health problems. For example, the young migrant child with undiagnosed hearing or vision problems will obviously experience difficulty in learning, regardless of the quality of the educational program presented. Other less obvious but equally significant undetected health conditions such as anemia, respiratory infections, otitis media and dental disease also contribute to listlessness and distraction due to pain which may inhibit the education process. Although it is axiomatic that children in poor health will not achieve their full educational potential, it is also critically important to view the development of healthful lifestyles and health practices as essential elements of each child's educational experience.

Working on a contractual arrangement with the Colorado Migrant Education Program, the Colorado Migrant Health Program recruits, hires, trains, and supervises seasonal health practitioners in summer migrant education schools throughout the state. The health services provided include: comprehensive health screening of all migrant school enrollees, treatment and follow-up for identified health problems, preventive dental services, and health education. Emphasis is placed on involving the family in health care. Therefore, health education and counseling takes place not only at the school site but also during school family nights and in homes. School health providers work closely with local Migrant Health staff and local providers to assure quality, comprehensive health care for migrant students.

Mutually supportive goals and the acknowledgment of the relationship between good health and the migrant child's ability to fully participate in the educational process set the stage for the 1987 Migrant Education Health Program.

The following sections detail the specific activities of the 1987 Migrant Education Health Program. This report is intended to meet the following general objectives:

1. To provide accountability to the Migrant Education Program that the health services provided were within the scope and financial estimates of the 1987 contractual agreement;

2. To share with Migrant Education staff and parents information gained about the relative health status and needs of migrant children in Colorado;

3. To provide an information base which will initiate planning efforts directed toward the 1988 Migrant Education Health Program.

HIGHLIGHTS OF 1987 PROGRAM

Significant health findings, changes, and highlights of the 1987 program are noted below. It is rewarding to note that the outcomes of the health screenings in 1987 suggest that there are gradual improvements each year in the overall health status of these children. Nonetheless, most of their health indices lag behind those for Colorado school children in general, reflecting the greater need for health services that continues to exist for migrant children.

HEALTH STATUS AND SERVICES

Vision

The prevalence of abnormal vision among migrant school children was 8.1% in 1987. While this constitues a slight improvement campared to the 8.3% prevalence observed among migrant school children in 1986, it remains significantly higher than the 6.0% prevalence observed among all Colorado school children. This difference is most likely due to the higher proportion of Colorado school children who have already had refractive errors identified and corrected with glasses.

Hearing

The criteria used for determining abnormal hearing were made slightly more stringent in 1987 in order to be exactly consistent with the standard used by Colorado schools in general (i.e., failing upon re-screening 4000 Hz at 25 dB, 2000 Hz at 20 dB, 1000 Hz at 20 dB, or 500 Hz at 25 dB). In 1987, 6.5% of Colorado migrant children were determined to have abnormal hearing. This is more than double the incidence of 2.8% observed for all Colorado school children in 1986-87. The reasons for this increased prevalence among migrant children cannot be pinpointed with certainty, but it is likely that important contributing factors are: 1) poor access to health care and underutilization of well-child services resulting in acute or chronic otitis media or serous otitis that is undetected until hearing screening takes place, 2) crowded and unsanitary living conditions which facilitate transmission of communicable illnesses which in turn cause secondary hearing disorders, and 3) inability to afford interventions such as hearing aids or medical treatment.

Dental

Significantly, there was a reduction of 3% in the number of children needing dental services compared to 1986. While it is impossible to draw conclusions because only 30-40% of the children return each year, there can be no doubt that the dental preventive program, including dental sealants, can be credited. This is ample justification to continue and increase these dental services.

Nutrition

Regrettably, due to funding constraints, significant cuts were made in the nutrition component of the Colorado Migrant Health Program. While 11 nutritionists provided services during the 1986 program, only four provided services in 1987.

Consequently, the structure and goals of the nutrition component changed. This year, the nutritionists' time was spent almost exclusively in the migrant family's home providing nutrition counseling. In past years, nutritionists had more time available to provide health education in the classroom and on family nights.

Some of the standards for abnormal nutrition values were altered in 1987 in order to focus the activities of the nutritionists upon only the highest priorities of nutritional need. Nutrition referrals were not made in 1987 for children who demonstrated short stature. For students who were underweight or overweight, diet counseling was provided for those whose weight for height was at or below the 5th percentile or at or above the 95th percentile. In previous years, these criteria had been less than the 10th percentile or greater than the 90th percentile.

The proportion of Migrant Education students found to be overweight was 9% in 1987. Since overweight was defined as at or above the 95th percentile weight-for-height based on NCHS statistics, only 5% would be expected to fall into this category. Thus, the prevalence of overweight among these migrant children is 80% greater than the general population.

In 1987, the criteria for abnormal hematocrit values were also changed so as to be more specific for anemia. As a result, diet counseling for borderline anemia was generally not provided in 1987 as it was in previous years. In 1987, students determined to be anemic received both nutritional counseling and therapeutic iron supplementation.

TB Skin Testing

The percentage of children with positive skin tests for tuberculosis continued to decline from 7% in 1985 to 3.6% in 1986, and to 2.3% in 1987. This is another gratifying improvement to observe. Follow-up was provided, through the cooperation of local health departments and county nursing services, to 100% of these children. (Note: Because the prevalence of positive skin tests among Colorado school children has been well under 1%, routine TB skin tests are generally no longer provided for them. However, among migrant children, the 2.3% rate of positive TB skin tests observed in 1987 substantiates the need to continue surveillance for this important public health threat among this high-risk population.)

Immunization Status

The nurses placed in the Migrant Education schools evaluated the immunization records of all children not in Colorado schools during the regular school year. This policy avoids duplication of the monitoring of immunization status required by the Colorado School Immunization Law. In 1987, 1,005 immunization records were evaluated and 174 children were given 324 needed immunizations.

Handicapped Children

Several migrant school children were identified as having handicapping conditions. Eleven referrals were made to the Handicapped Children's Program for such conditions as hearing loss, blindness, club feet, cerebral palsy, and neurologic syndromes.

HEALTH RECORD

The Health Data Entry Form (HDEF) is the form used in the Migrant Education Program to submit health data to the Migrant Student Record Transfer System (MSRTS). Believing that the HDEF used in previous years did not provide health team members and school staff with the most appropriate, accurate health history information, a major change in the HDEF was introduced in 1987. The number of health history questions was reduced to 12. These 12 questions are written in both English and Spanish on the form, and the school recruiter asks parents questions verbatim from the form. This method of generating health history information helps to assure the reliability of the health information that is the most critical to the health team members.

Part I of the HDEF is now a three-part NCR form containing health history information. One copy is placed in the dental chart, one in the school health chart, and one is submitted to the MSRTS.

Part II of the HDEF contains immunization information, health screening results, and a listing of significant active problems. Part II is a two-page NCR form. One copy is placed in the school health chart, and one copy is submitted to MSRTS.

By using NCR paper, data can be submitted directly to terminal operators for input into MSRTS. In the past, records clerks had to transfer information from one form to another.

A sample copy of the HDEF is included at the end of the appendix.

PROFESSOR BODYWISE

Professor Bodywise, a health education presentation provided as a community service through Kaiser Permanente, was performed at the Ft. Lupton summer school. This puppet/drama presentation dealt with such health issues as safety, nutrition, alcohol, smoking, drugs, and exercise. It was well received by the students and staff. It is hoped that this performance can be included in additional schools next year.

HEALTH PROFESSIONAL STUDENTS

In 1987, a total of 21 health professional students and interns participated in the Migrant Education Program. Those selected to participate in the program are highly motivated, independent, culturally sensitive, and have demonstrated a high level of competence in their academic and clinical training. Because of their skills and enthusiasm, these students make valuable contributions to health care delivery and health education. In 1987, 12 nursing students (10 from the University of Colorado, one from Metropolitan State College, and one from the University of Northern Colorado) were placed in Migrant Education schools throughout the state. In addition, five dental hygiene students and four Child Health Associate Students/Interns from the University of Colorado provided services to migrant school children.

Students evaluating their community health experience with the Migrant Education Health Program see it as a valuable learning experience. Many students become providers in community or rural health care settings after graduation.

PARENT ADVISORY COUNCIL

Although the Colorado Migrant Health Program has for many years had extensive interaction with both the statewide Parent Advisory Council (PAC) and with PAC's at the local level, this relationship was formalized in 1987. Beginning in April of 1987, the statewide PAC agreed to serve as a formal mechanism to assure that migrants have active participation in decisions that govern the operation of the Colorado Migrant Health Program.

Because more than one-half of Migrant Health Program users are 19 years of age or younger, parents of migrant children can offer important advice in identifying the needs of migrant children and evaluating the effectiveness of services that are provided. Additionally, because all members of the PAC's are either current or former migrants, or persons active in the provision of migrant services, PAC's are also a significant resource in evaluating the health services offered to adults.

The types of advice offered in 1987 included: the health services to be provided in 1988, the types of health providers necessary, the locations and times of services, fee schedules and collection mechanisms, satisfaction with service providers, etc. The Colorado Migrant Health Program is grateful for the willingness of the PAC to accept this additional resonsibility. Enhancing what has already been a close collaborative relationship can only serve to further strengthen the full range of migrant services in Colorado.

MIGRANT EDUCATION NURSE COORDINATOR

1987 marked the addition of a year-round migrant education nurse coodinator to the staff of the Colorado Migrant Health Program. In the past, the nursing coordinator has worked only during the high-impact months of migrant services. By working year-round, the nursing coordinator is able to focus efforts on strategic planning for the summer migrant education program and bring greater continuity and expertise to this program.

COMMUNITY PARTICIPATION

A disturbing trend that has become increasingly more evident in the past few years is the decline in the participation of local community members and organizations in the provision of goods and services to migrants. This is especially evident in the ability of local service orgnizations, particularly the Lions Club, to assist migrant children needing eyeglasses. Whereas five years ago nearly one-half of the children needing eyeglasses were assisted, in 1987 only Alamosa and Grand Junction Lions Clubs offered help. Although donations from community organizations in Alamosa were extremely generous ($880 total), this assistance was available only after a highly publicized visit by Governor Romer and his Cabinet and the elevation of the need in a public forum.

Although this decline in participation (corresponding as it does to increases in federal deficits and decreases in federal assistance) most probably reflects a lack of ability, not desire, the impact on the migrant health program has been significant. Further erosion of community assistance can only result in further declines in services received by migrant children.

SECTION I
HEALTH PROGRAM OVERVIEW

Service Population Profile

A total of 1,826 migrant children in migrant education schools received one or more services from the Colorado Migrant Health Program during the summer months of 1987. This number includes 79 preschool age children who were served at the Longmont, Fort Collins, and Fort Morgan school sites. Figure I shows the number of students in the different age groups as well as the proportion of male to female students. Students ranged in age from less than 1 through age 19 with the majority (72.6%) between the ages of 5 and 11. 50.8% were female and 49.2% were male. Not surprisingly, the ratio of male to female students changes when looking at the 12 through 19 year old age group. In this group, 41.5% of the students were male and 58.5% of the students were female. This reflects in part the number of older male students who work rather than attend school, most often because of family financial necessity.

Migrant student enrollees were predominately Hispanic (97.5%) with the remaining students being Anglo, Indian, and Black. Table I reflects the ethnic status.

FIGURE I

AGE AND SEX OF
MIGRANT EDUCATION ENROLLEES
-1987-

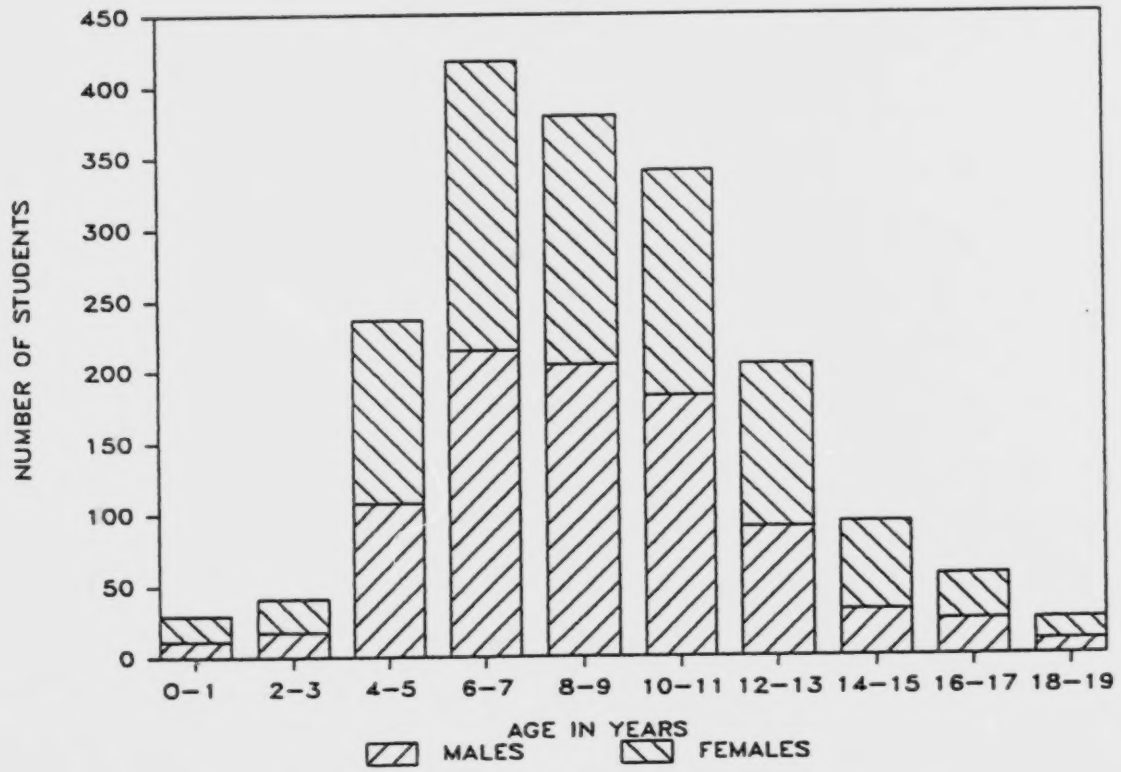


TABLE I

ETHNIC STATUS OF
MIGRANT EDUCATION ENROLLEES
-1987-

ETHNICITY	FREQUENCY	PERCENT
HISPANIC	1,780	97.5%
ANGLO	22	1.2
INDIAN	20	1.1
NATIVE AMERICAN	4	0.2
TOTAL	1,826	100 %

Service Providers

In order to provide a full continuum of health care, two categories of health providers are required: 1) nearly 200 local providers (physicians, dentists, pharmacists, allied health providers) either in private practice or working with community-based care organizations, and 2) seasonal-hire staff who are recruited nationwide for the duration of the Migrant Education summer schools. During 1987, 77 health providers were hired on this basis. This included:

- 15 Registered Nurses
- 21 Dental Hygienists
- 4 Nutritionists
- 21 Dental Students or Recent Graduates
- 12 Nursing Students
- 4 Child Health Associate Students/Interns

These health providers worked as a multidisciplinary team and were deployed to all 12 Migrant Education summer school sites. The placement of these providers is displayed in the following table:

TABLE II

DEPLOYMENT OF SEASONAL HEALTH PROVIDERS *
-1987-

Site	Nurses	Nutritionists	Dental Hygienists	Dental Students	Nursing Students
Ft. Lupton	1	0.3	2	2	2
Brighton	1	0.3	3	2	1
Longmont	2	0.4	2.5	2	1
Ft. Collins	1	0.3	2	2	1
Greeley	2	0.4	2	2	1
Ft. Morgan	1	0.3	1	2	1
Lamar	1	0.5	1.5	1	1
La Junta	1	0.5	2	2	1
Pueblo	1	0.5	1	2	0
Alamosa	2	0.5	2	2	2
Delta	1	0	1	1	1
Grand Jct.	1	0	1	1	0
TOTAL	15	4	21	21	12

* In addition, Child Health Associate (CHA) Students and Interns worked in the following areas:

Longmont - 1 CHA Intern (1/2 time)
- 1 CHA Student (1/2 time)

Alamosa - 1 CHA Student

Rocky Ford - 2 CHA Interns (1 month each)

In Burlington, health services were provided by the local county nurse.

Health Encounters

During the summer of 1987, 1,826 migrant education enrollees had a total of 12,059 encounters with health personnel from the Colorado Migrant Health Program. This represents an average of 6.6 encounters per student.

A health encounter is defined as a face-to-face interaction between a health provider and a student (or the student's parent) which requires independent judgment based upon the health provider's training and is of sufficient importance to be recorded in the patient's chart. Health care encounters are divided into the following categories:

1. New and repeat medical encounters

2. New and repeat dental encounters

3. New and repeat nutrition encounters

"New" medical, dental, and nutrition encounters are those that happen during the first interaction with the student. "Repeat" encounters are those that happen subsequent to the initial (new) contact and are either follow-up to the condition identified during the initial contact or new health conditions which have arisen after the first contact.

The following table presents the number of encounters by service category:

TABLE III

NUMBER OF PATIENT ENCOUNTERS
-1987-

SERVICE CATEGORY	CATEGORY FREQUENCY	TOTAL	PERCENT OF TOTAL
MEDICAL		5,338	44.3%
New	1,801		
Repeat	3,537		
DENTAL		6,472	53.7
New	1,712		
Repeat	4,760		
NUTRITION		249	2.0
New	242		
Repeat	7		
TOTAL	12,059	12,059	100%

It is also of interest to note the sites at which these services were delivered to migrant children. The following table reflects this information:

TABLE IV

PATIENT ENCOUNTERS
BY SITE OF SERVICE
-1987-

SERVICE SITE	FREQUENCY	PERCENT
MIGRANT EDUCATION SCHOOLS	7,915	65.6%
MIGRANT EDUCATION NIGHT SCHOOLS	193	1.6
DENTAL OFFICE	2,998	24.9
PHYSICIAN OFFICE	421	3.5
STUDENT'S HOMES	359	3.0
CMHP CLINIC	102	0.8
HOSPITAL	25	0.2
HEALTH DEPARTMENT/WIC	46	0.4
TOTAL	12,059	100%

As is evident from the preceding table, 67.2% of all students were offered services at a school site. Offices of medical and dental practitioners were the next most frequent sites of services (28.4%) followed by services delivered in the home (3.0%).

It is of additional interest to examine where services were delivered by individual health practitioners. The following tables reflect the sites of service delivery by nursing, dental hygiene and nutrition personnel:

TABLE V

NURSING* ENCOUNTERS BY
SERVICE DELIVERY SITES
-1987-

SERVICE SITE	FREQUENCY	PERCENT
MIGRANT EDUCATION SCHOOLS	4,216	93.0%
MIGRANT EDUCATION NIGHT SCHOOLS	97	2.1
HOME	155	3.4
CMHP CLINIC	23	0.5
OTHER**	45	1.0
TOTAL	4,536	100%

NOTES: *Includes Migrant Education nurses, CMHP nurses, nursing students and health aides.

**Includes physician's office and health departments.

TABLE VI

DENTAL HYGIENE ENCOUNTERS
BY SERVICE DELIVERY SITES
-1987-

SERVICE SITE	FREQUENCY	PERCENT
MIGRANT EDUCATION SCHOOLS	3,374	93.4%
MIGRANT EDUCATION NIGHT SCHOOLS	81	2.2
HOME	15	0.4
DENTAL OFFICE	137	3.8
CMHP CLINIC	5	0.2
TOTAL	3,612	100%

NOTE: This table does not reflect the encounters by dentists and dental students.

TABLE VII

NUTRITION ENCOUNTERS BY
SERVICE DELIVERY SITE
-1987-

SERVICE SITE	FREQUENCY	PERCENT
MIGRANT EDUCATION SCHOOLS	46	17.1%
MIGRANT EDUCATION NIGHT SCHOOLS	13	4.8
HOME	186	69.2
CMHP CLINIC/WIC/HEALTH DEPT.	24	8.9
TOTAL	269	100%

It is significant to note that approximately 93% of all nursing and dental hygiene encounters took place at a Migrant Education school site. This contrasts with the nutrition encounters where only 17% took place in school sites and 69% in the students' homes. This is reflective of the high priority placed by the nutrition component on engaging the whole family in nutrition services. Additionally, during home visits, nutritionists frequently address other health concerns with the family after consultation with the nursing and dental components.

SECTION II

HEALTH STATUS OF MIGRANT EDUCATION STUDENTS

Migrant children experience the same kinds of illnesses that are common to all children. However, it is generally observed that, for a variety of reasons, their overall health status is poorer than that of non-migrant children in Colorado and in the United States. Poverty, limited education, linguistic differences, and other factors interfere with access to both preventive health care (including immunizations, nutritional imbalances, identification of impaired hearing, vision, or development, etc.) and health care for acute and chronic illnesses. As a result, a significant amount of preventable illness occurs, with dental disease being primary among these. Other disease states that are not promptly identified may be allowed to progress and become more serious or even develop irreversible complications. Crowded housing and poor sanitation conditions also contribute to an excess of communicable diseases, ranging from relatively benign respiratory infections to tuberculosis. In addition, injuries are common among older migrant children who work in the fields as well as among their younger siblings who may have no safe places in which to play.

In order to promptly identify the most common important health problems found in these children, they are given routine evaluation in the following areas during the summer school program:

1. height and weight, in order to identify overweight and underweight,
2. hematocrit in order to identify anemia,
3. audiometry, in order to identify abnormal hearing,
4. vision testing,
5. screening for scoliosis (for 11-year old children),
6. blood pressure,
7. dental examination,
8. PPD skin test for tuberculosis (as indicated).

In order to identify the presence of these conditions as soon as possible (so that intervention may be offered while the children are available for services), all health team members participate in screening clinics conducted during the first week that children attend migrant summer schools. Screening is offered thereafter on a weekly basis to identify health problems in students who begin attending at a later date. The following is a summary of the screening procedures offered:

Height and weight measurements are taken on all migrant school children. Results are plotted on a National Center for Health Statistics (NCHS) growth chart. Underweight is defined as being at or below the 5th percentile, weight for height, on the growth chart. Overweight is defined as being at or above the 95th percentile, weight for height. Follow-up for children determined to be overweight or underweight consists of diet assessment, assessment of the child's medical history, and individual counseling with the child and the child's family.

Hematocrits are done to assess the possibility of iron deficiency anemia. Children are identified as being anemic if their hematocrit reading is below the indicated level:

Age		Hematocrit
6 mo.-2 years		< 33
3 - 4 years		< 34
5 - 9 years		< 35
10-14 years		< 36
15-18 years	male	< 39
	female	< 36
18 years +	male	< 42
	female	< 36

Children with anemia are referred to a nurse for treatment with iron supplements and also are followed-up by the nutritionist. Follow-up consists of diet assessment, assessment of the child's medical history, and individual counseling with the child and the child's family. Children with abnormal hematocrits are rescreened at intervals during the summer to assess whether or not the anemia has been resolved or improved.

Blood pressures are taken for two reasons. The first reason is that elevated blood pressure may indicate serious disorders such as kidney disease or cardiovascular disease. The second reason is that blood pressure measurements serve as baseline data on a child so that the child's "normal" blood pressure can be established for future reference. A blood pressure is considered to be abnormal if it is greater than a certain reference point on three different occasions. The criteria used to identify abnormal blood pressure is as follows:

Age	B/P Greater Than
<6	110/75
6 - 10	120/80
10 - 14	125/85
14 - 18	135/90

If the blood pressure is found to be elevated on three different occasions, the child is referred to a physician. The nutritionist may do diet counseling if it is determined that the elevated blood pressure is complicated by the child's nutritional status (eg. obesity).

Hearing screening is conducted on all testable students (some students may be too young to understand the screening instructions and are therefore untestable). A child must hear the tone in both ears at the following levels in order to pass the hearing screening:

4000 Hz at 25 dB
2000 Hz at 20 dB
1000 Hz at 20 dB
500 Hz at 25 dB

If a child fails the hearing screening, he is rescreened on another day unless there is evidence to suggest the presence of otitis media. (If there is such evidence, the nurse will immediately refer the child to a physician and rescreen the child's hearing after resolution of the infection.) Children who fail screening twice are referred to a local audiologist for further diagnostic evaluation.

Scoliosis screening is done on all 11 year old children by the Migrant Education Nurse. This screening procedure is done to detect any lateral curvature of the spine which, if present, may worsen during the adolescent growth spurt. Abnormals are rescreened, and, if still abnormal, are referred to a medical provider for evaluation and possible x-ray. If there is need for immediate intervention, the child is referred to the Handicapped Children's Program.

Vision screening is done on all testable children using a Snellen "E" chart. The following criteria constitute a failed vision screen:

3-4 year old:	if 20/60 or worse either eye
5 year old:	if 20/50 or worse either eye
6 years and older:	if 20/40 or worse either eye

If a child fails the vision screening, he is retested another day. If he fails a second time, a referral to an optometrist or opthalmologist is made. Children are also referred if they demonstrate a two-line differential (eg. 20/20 OD, 20/40 OS) on the Snellen chart.

Dental screening consists of an examination of the teeth and oral structures. The purpose of this screening is to identify those children in need of professional dental treatment.

Dental screening is done by one of the dental providers, most often the dental hygienist. At the time of screening, the children are prioritized according to the severity of need. Children with the most serious treatment needs are referred first for care, with less serious conditions being referred as time and financial resources allow. Because dental problems are related in part to poor nutrition and oral hygiene practices, referrals to the dental hygienist and/or nutritionist for counseling and education are also made at the time of screening.

PPD (Purified Protein Derivative) testing is a skin test which determines exposure to the tuberculosis bacillus. This screening procedure is arranged by or performed by the Migrant Education Nurse on students who do not attend school in Colorado during the regular school year and who have never been tested, or who are kindergartners and seventh graders who have not been tested within the past three years. The skin test is read 48 to 72 hours later. Children with positive tests are referred to local health departments or county nurses for chest x-rays and other follow-up. This procedure requires signed parental consent.

The following table reflects the "abnormal" findings identified through the screening process in 1987:

TABLE VIII

MIGRANT EDUCATION
SCREENING OUTCOMES
-1987-

SCREENING PROCEDURE	NUMBER SCREENED	NUMBER ABNORMALS	PERCENT ABNORMAL
HEIGHT/WEIGHT:			
Overweight	1,687	158	9.4%
Underweight	1,687	47	2.8
HEMATOCRIT	1,687	80	4.7
BLOOD PRESSURE	1,689	0	0
HEARING	1,684	110	6.5
SCOLIOSIS	173	5	2.9
VISION	1,684	136	8.1
TB SKIN TESTS	177	4	2.3
DENTAL	1,693	1,013	59.8

Diagnostic Data

For all significant encounters between health care providers and migrant education students, diagnostic information is recorded, coded, and tabulated so that the incidence of illness episodes experienced by these children during the six to eight weeks of the summer school program can be analyzed. This diagnostic data provides important information regarding the health status and health needs of this population.

Table IX shows the total incidence during the 1987 Migrant Education summer school program of illness episodes in terms of diagnostic categories. (These figures represent new illnesses only, not the total number of encounters for illnesses).

TABLE IX
MIGRANT EDUCATION
DIAGNOSTIC FREQUENCIES
-1987-

DENTAL	
Caries	1013
Gingival/Perio Disease	564
Oral Trauma	12
TOTAL	1589
DISEASES OF THE EYE, EAR, NOSE, AND THROAT	
Abnormal Vision	136
Hearing Loss	110
Otitis Media	72
Epistaxis (nosebleed)	38
Conjunctivitis	24
Serous Otitis	14
Cerumen (wax)	12
Allergies/Hayfever	8
Other EENT	42
TOTAL	456
INJURIES	
Abrasion/Bruise	145
Laceration/Puncture	71
Sprain/Strain	37
Insect/Animal Bite	28
Fracture	14
Burn	10
Other Injuries	77
TOTAL	382
NUTRITION-RELATED	
Overweight for Height	158
Anemia	80
Underweight for Height	47
Other Nutritional	68
TOTAL	353
COMMUNICABLE DISEASES	
URI/Cough/Sore Throat	118
Pediculosis (head lice)	52
Other Viral Syndromes	41
Strep Throat Infections	28
Tuberculosis	4
Other Communicable Dis	57
TOTAL	300
DISEASES OF THE SKIN	
Infection/Cellulitis	15
Impetigo	10
Contact Dermatitis	7
Eczema	4
Hives	3
Other (warts, rashes, etc)	86
TOTAL	125
GASTROINTESTINAL DISORDERS	
Abdominal Pain	61
Diarrhea/Vomiting	18
Ulcer/Gastritis	2
Other Digestive	12
TOTAL	93
NEUROLOGIC	
Headache	75
Dizziness/Fainting	8
Epilepsy/Seizure	3
TOTAL	86
GENITOURINARY/GYNECOLOGIC	
Urinary Tract Infect	12
Menstrual Problem	5
Vaginitis	5
Pregnancy	1
Other GU/GYN	10
TOTAL	33
OTHER	
Fever	25
Psycho-Social Problems	15
Fatigue/Malaise	10
Arthritis/Joint Pain	6
Heart Murmur	5
Scoliosis	5
Chest Pain	4
Abnormal Development	3
History Rheumatic Fever	2
Birth Defect	2
Other	22
TOTAL	99

Table X summarizes the incidence of illness episodes for each broad diagnostic category, and Figure II displays the information graphically in terms of incidence of illnesses in each diagnostic category per 100 students who received health screening. This means that, during the summer program, for every 100 students, there were 60 who had dental caries, 34 episodes of gum disease or other dental problems, 27 disease episodes of the eyes, ear, nose, and throat (including hearing or vision problems), etc. It should be noted that these incidence rates provide an under-representation of the actual incidence of illnesses for a number of reasons. For example, many children were not present in the area during the entire summer and had undocumented health problems during this time. Illnesses which occurred over the weekend or which prevented children from attending school may have been missed. When illnesses or abnormalities were found upon screening, screening codes were sometimes used instead of diagnostic codes for these illnesses. Similarly, coded documentation of diagnoses may have been incomplete for children with several simultaneous health problems.

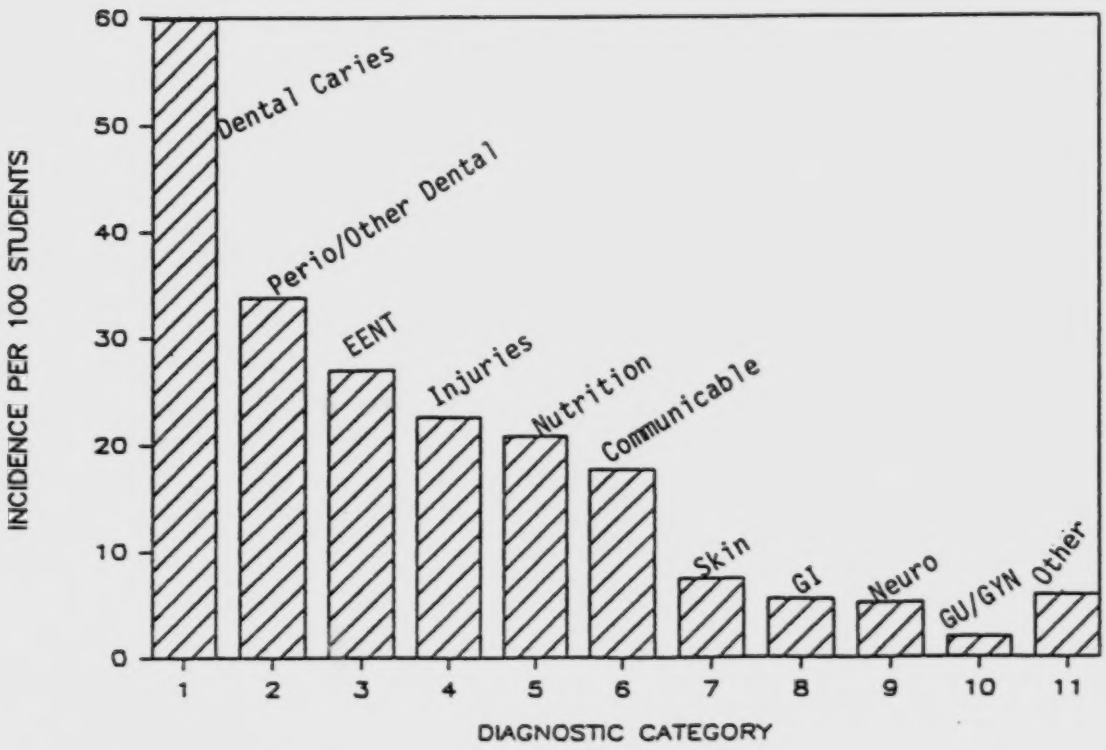
TABLE X

NEW ILLNESS BY DIAGNOSTIC CATEGORY -1987-

Diagnostic Categories	Rank	Incidence	Rate/100 Students
Dental Caries	1	1013	59.8
Perio Disease/Other Dental	2	572	33.8
Eye, Ear, Nose, and Throat	3	456	26.9
Injuries	4	382	22.6
Nutritional Disorders	5	353	20.9
Communicable Diseases	6	300	17.7
Diseases of the Skin	7	125	7.4
Gastro-Intestinal Disorders	8	93	5.5
Neurologic	9	86	5.1
Genitourinary/Gynecologic	10	33	1.9
Other	11	99	5.8

FIGURE II

INCIDENCE OF NEW ILLNESS
PER 100 STUDENTS
-1987-



In order to evaluate the health status of Migrant Education children served in Colorado in 1987, analysis of this diagnostic information should be compared with similar information obtained from other school-age populations. Unfortunately, there is limited data available from other populations that is truly comparable. The best comparable data has been obtained from school health screening of children in Colorado during 1986-87 and includes results of vision screening, hearing screening, and skin test screening for tuberculosis, for each of which identical criteria were used to determine normal or abnormal screening results. Compared with Colorado school children, 1987 Migrant Education students were found to have 33% higher incidence of abnormal vision and 136% higher incidence of abnormal hearing. Migrant Education students experienced a 2.3% rate of positive reactions to a PPD skin test for tuberculosis, compared with less than 1% reactivity among Colorado school children.

The proportion of Migrant Education students found to be overweight was 9% in 1987. Since overweight was defined as at or greater than the 95th percentile weight-for-height based on NCHS statistics, only 5% would be expected to fall into this category. Thus, the prevalence of overweight among these migrant children is 80% greater than the general population. That obesity is a significant nutritional problem for these children is also borne out by the somewhat low proportion found to be underweight. Defined as at or less than the 5th percentile of weight for height, 3% of Migrant Education students were found to be underweight, compared to an expected 5%.

The importance of obesity as a risk factor for these children becomes additionally significant when one considers the risk of diabetes in this population. Owing to genetic factors, Hispanics have two to four times the risk of developing diabetes mellitus compared to whites, even when one controls for obesity. Since there is additional risk of developing diabetes associated with obesity, the importance of addressing and controlling overweight in migrant children is significant.

While these data show some improvement in the health status of migrant children, it is clear that they suffer much poorer health than non-migrant children their ages.

As is readily apparent from Table X and Figure II, dental disease is the major health problem for migrant children with 1,013 students (59.8%) having identifiable dental problems. 37 (2%) were identified as requiring immediate referral for relief of pain and/or treatment of dental infection.

The following preliminary statements may be offered:

- 71.3% of students with identified dental problems received complete treatment;

- 8.2% of students with identified dental problems received partial treatment;

- there were a total of 2,870 visits to dental offices, an average of 3.6 visits per child receiving treatment;

- 6.3% of students with identified dental problems were not referred for treatment because their dental problems were low priority;

- 15.0% of students with identified dental problems were not referred due to one of the following reasons: the student had their own dentist, had poor attendance, moved before dental treatment could be initiated, or because a parent did not sign a consent form.

In addition to treatment offered for acute and chronic dental problems, substantial emphasis was placed on preventive dental services. During the 1987 summer school session, a total of 1,495 students received dental prophylaxis and fluoride application treatments. This represents 88% of the children receiving dental screenings. Portable dental equipment made it possible for the dental hygienist to provide the majority of this treatment within the school setting.

Pit and fissure dental sealants were provided again this year. A pilot project in 1983 in Longmont, Brighton, and Fort Lupton proved an overwhelming success. Expansion of the program from 1983 to 1987 continued. One dental hygienist with specialized equipment was hired to travel from school to school to place sealants.

Sealants are a clear resin material that is placed on acid etched chewing surfaces of teeth. The material flows into the deep pits and fissures and hardens. Sealants are effective in preventing decay in these surfaces up to five years. Fluorides protect the smooth surfaces of the teeth from decay. Therefore, they will also be continued.

SECTION
III

HEALTH EDUCATION

As noted in the introduction of this report, in order to enhance the general health status of the migrant farmworker population it is necessary to place a high priority on assisting migrant children to develop healthful lifestyles and health practices.

Health Education Curriculum

A major effort in 1987 was again directed toward the incorporation and integration of health education units on selected health education topic areas into the migrant school curriculum (MSS-HEC). The topic areas selected were Dental Health, Nutrition, Safety Education, Personal Hygiene, Wellness, and Sex Education.

The units were developed for Level I (lower elementary), Level II (upper elementary), and Level III (grades 6-8). Each topic area and level have two to four classroom lessons developed around specific, measurable learning objectives. Each lesson contains:

1. A concept sheet for the teacher with basic background information on the subject matter,

2. Learning objectives and related bilingual activities,

3. Supplemental materials which include hand-out pamphlets, student worksheets, and related activities in other classes,

4. Evaluation instruments.

Utilization of the MSS-HEC curriculum was reported on forms placed in each MSS-HEC box and is reported in Table XI. Although the number of sessions and participants increased from 1986, reported usage is still considerably lower than in 1985. The number of schools using the MSS-HEC box has dropped from 10 in 1985 to five in 1987. This year, of the 47 sessions taught, 35 were taught by teachers, seven by nursing staff, and five by dental staff.

TABLE XI

MSS-HEC UTILIZATION
THREE YEAR COMPARISON
-1987-

Year	Number of Sessions	Number of Participants	Number of Schools
1985	323	5,499	10
1986	33	469	7
1987	47	1,523	5

NOTE: These figures represent information tabulated from the utilization forms attached to the lids of returned boxes. There is no way to measure the underreporting.

Even though underreporting may have occurred, these usage figures indicate the need for serious evaluation of the future use of MSS-HEC. The Migrant Health and Migrant Education Programs will be working with individual Migrant Education Directors. Evaluation and planning will focus on the feasibility of the MSS-HEC curriculum in individual schools and the most effective approach to health education.

Health Education Activities

All health team members were charged with the responsibility of engaging in a number of health promotion activities. These activities involved participation in classroom education, discussion groups, staff inservice training, and presentations at family nights. Table XII shows the number of health education/promotion activities offered by education category. Tables XXXII, XXXIII, and XXXIV in the appendix detail health education services provided by nurses, dental hygienists, and nutritionists in each site.

TABLE XII

HEALTH EDUCATION/PROMOTION
ACTIVITIES
-1987-

EDUCATION CATEGORY	GROUP/CLASS-ROOM SESSIONS	# PERSONS ATTENDING	STAFF IN-SERVICES	# PERSONS ATTENDING	FAMILY NIGHT PRESENTATIONS	# PERSONS ATTENDING
Nursing	86	2,151	5	48	12	423
Dental	94	1,949	2	31	8	380
Nutrition	35	583	21	339	5	325
TOTALS	215	4,683	28	418	25	1,128

The number of health promotion activities conducted by the Migrant Health Teams increased from 1986. In 1986 a total of 202 health education/promotion sessions involving 4,044 people were held. In 1987, 268 sessions involving 6,229 people were held. 215 classroom education and small group sessions involved 4,683 attendees. 28 staff inservice training sessions included 418 attendees. 25 family night presentations involved a total estimated audience of 1,128.

Classroom education and group sessions included the topics contained in the MSS-HEC curriculum (dental health, nutrition, safety education, personal hygiene, wellness, and sex education). In addition, other health education topics addressed were: stress, alcohol abuse, first aid, back pain and body mechanics, skin care, smoking, self-esteem and AIDS.

Family night presentation topics included: how to read a thermometer, bottle mouth caries and sugar substitutes, blood pressure, general nutrition, and the relationship between bottle propping and ear infections. The topics were presented in the form of skits, puppet presentations, group interactions, and one on one counseling.

Staff inservice topics included information on summer health services, hypertension, and AIDS.

SECTION
IV

FINANCIAL RESOURCES

In order to deploy a comprehensive health program for the 1,826 students enrolled in the 13 Migrant Education summer schools, it was necessary to carefully coordinate a variety of financial resources. The following table reflects the financial requirements and sources of revenue for the Migrant Education Health Program.

TABLE XIII

FINANCIAL REQUIREMENTS AND SOURCES OF REVENUE MIGRANT EDUCATION HEALTH PROGRAM -1987-

	Total Revenue Required	Sources of Revenue			
		Colorado Migrant Health Program	Maternal Child Health Grant	*Other	Colo. Dept. of Educ.
Personnel	$184,658	$33,658	$36,313	$58,149	$56,538
Travel	10,388	4,331			6,057
Recruitment	671	671			
Orientation	7,832	4,832			3,000
Supplies	8,891	7,309			1,582
Treatment	166,258	14,704	23,687	96,015	31,852
Total Direct Costs	378,698	65,505	60,000	154,164	99,029
Indirect Costs	21,779	10,808			10,971
Grand Total	$400,477	$76,313	$60,000	$154,164	$110,000
	(100%)	(19.0%)	(15.0%)	(38.5%)	(27.5%)

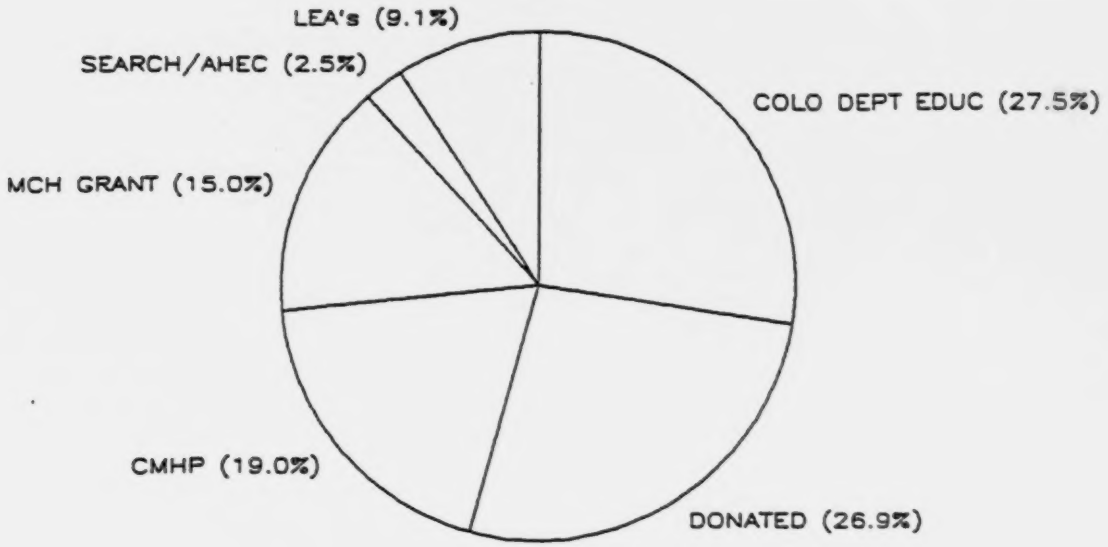
*Other sources include:

1. SEARCH/AHEC	$ 10,000
2. Donated Services	107,589
3. LEA Contribution	36,575
	$ 154,164

The percentage of funds received from the revenue sources is depicted graphically in the following figure:

FIGURE III

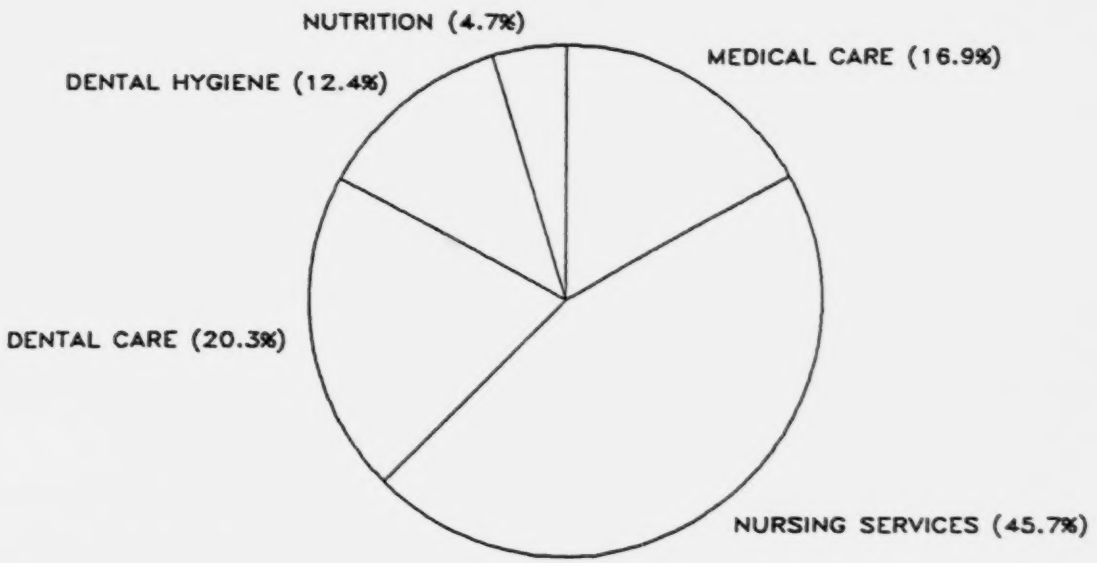
SOURCES OF REVENUE
MIGRANT EDUCATION HEALTH PROGRAM
-1987-



Allocation of all resources is depicted in the following figure:

FIGURE IV

ALLOCATION OF RESOURCES
MIGRANT EDUCATION HEALTH PROGRAM
-1987-



The specific contribution of the Migrant Education Program to the 1987 program effort is displayed in Table XIV and is depicted graphically in Figure V

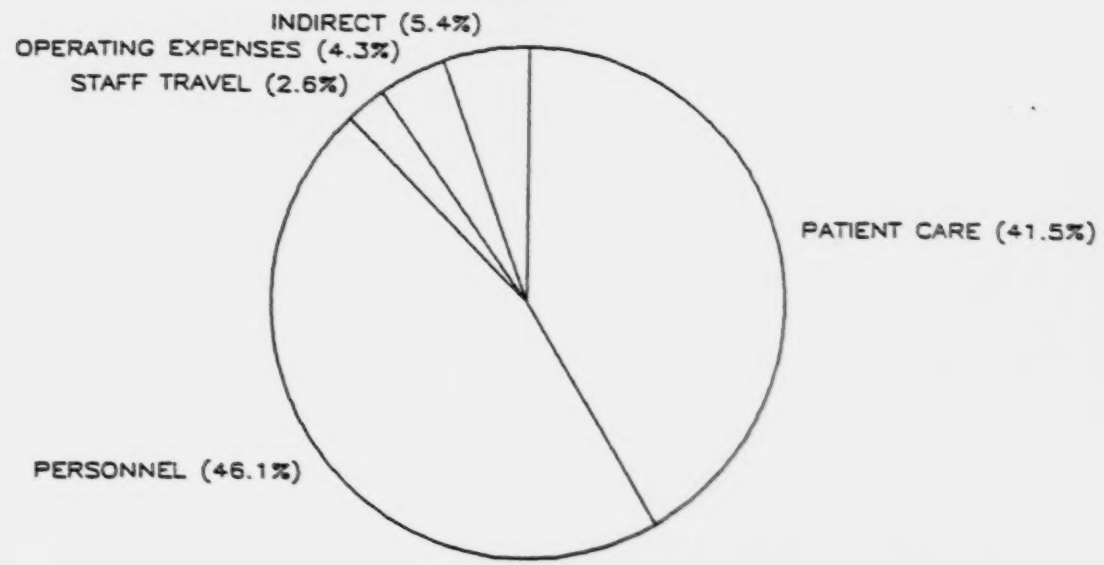
TABLE XIV

MIGRANT EDUCATION CONTRIBUTION
ALLOCATION BY SERVICE CATEGORY
- 1987 -

COST CATEGORY	AMOUNT ALLOCATED	PERCENT OF MIGRANT EDUCATION BUDGET
Medical Care	$ 18,564	16.9 %
Nursing Services	50,231	45.7
Dental Care	22,369	20.3
Dental Hygiene Services	13,638	12.4
Nutrition Services	5,198	4.7
TOTAL	$ 110,000	100 %

FIGURE V

MIGRANT EDUCATION
BUDGET ALLOCATION
BY SERVICE CATEGORY
-1987-



It is significant to note that although services were offered to Migrant Education Students at a cost to the Department of Education of $110,000, the total value of services offered far exceeded this amount. This is due to contributions from other sources of revenue and the cost-effective mechanisms which have been developed over the past several years. The dental component offers a number of tangible examples of this cost-effectiveness:

When dental services are provided by a dental student under the direct supervision of local dentists, the cost to the program is only 1/3 to 1/2 the usual and customary charge;

When dental services are provided at the Mesa County Health Department, there is no charge beyond the monthly stipend paid to the dental graduate who staffs the clinic;

Both Plan de Salud del Valle and Sunrise Community Health Center provide comprehensive dental services to migrant students in Adams, Weld and Boulder Counties in return for minimal payments.

SECTION V

PREPARING FOR 1988

Program year 1988 will present a set of major challenges and opportunities to Colorado's Migrant Health/Migrant Education partnership.

The most obvious challenge for both organizations will be to continue providing an essential range of health and education services to our mutual target population while we are receiving declining financial resources with which to operate. For example, for the past five years CMHP has received level funding from all four major sources of funding for the Migrant Education Health Program (DHHS/PHS, Colorado Department of Education, SEARCH/AHEC, LEA's). At the same time health care costs have been rising faster than the rate of inflation. Although three of these sources will remain constant in 1988, the National Migrant Health Program (DHHS/PHS) just took a 4.3% reduction from the 1987 funding level. It is anticipated that a portion of this reduction will be absorbed by reducing the level of national discretionary spending. Nonetheless, some level of reduction will be felt at the state and program level. We anticipate that continued close and supportive relationships between the Migrant Education and Migrant Health Programs will assure that priorities and service reductions will continue to be made with a high level of sensitivity to the needs of migrant children.

Opportunities for both programs may arise as a result of the implementation of the Immigration Reform and Control Act in Colorado. Health agencies will be able to take advantage of a new payment mechanism for a number of newly legalized children (and parents) thus freeing up some monies to mitigate budget reductions from other sources. Education agencies will be able to expand services to newly legalized adults and adolecents, thus reinforcing for migrant children the importance and desirability of a good basic (and open-ended) education.

In order to assure that the health service delivery plan for 1988 is responsive to the needs and resources of both the Migrant Education Program and the Migrant Health Program, the two programs are currently evaluating data from the 1987 program and working together to develop objectives and strategies for the 1988 program. In consultation with local migrant education and migrant health staff, area-specific service delivery plans will be developed for each local program.

Targeted areas to be addressed in planning for the 1988 program include the following:

Health Education

In view of the trend of decreased utilization of the MSS-HEC curriculum, migrant education and migrant health staff will be working with individual migrant education directors and teaching staff to redefine goals of the curriculum and identify the committment of the staff. Efforts will be made to work at the local level to devise a site-specific approach to health education. AIDS education and child abuse prevention education will be targeted issues for inclusion.

Volunteers

In order to support efforts of migrant health seasonal staff to spend more time directly with the parents of migrant eduacation students, a major effort will be mounted in 1988 to recruit bilingual volunteers to assist non-Spanish speaking health team members. In addition to providing translation assistance as important health information is communicated, with a modest investment in training, many additional supportive functions may be undertaken (e.g., assessing patient satisfaction, limited compliance monitoring, obtaining informed consents for immunizations, providing limited follow-up services after seasonal providers complete their assignment).

Life Choices

Following a successful pilot program in 1986, a search for funding is currently underway in order to implement "Life Choices" Clubs in five summer school sites in 1988. Developed by Big Sisters of Colorado, the Life Choices Club concept places 12-14 girls aged 10-13 in a club-like atmosphere three times a week for two hours. A highly refined curriculum is utilized to help the girls experience the power they have to make choices in their lives and about their lives. Topics and issues discussed and experienced include: personal values, career awareness, personal, family and group decision-making, assertiveness, body image, sexuality, and friendships. The total experience is designed to develop, reinforce, and emphasize the power individuals and families have in making conscious "Life Choices". Visits to potential career and health sites are a focused part of the curriculum. The evaluation of this experience in 1986 was highly favorable, and we feel it has the potential to satisfy the requests of several years standing from Migrant Education staff who want an effective family life/sex education program for adolescents and preadolescents. One of the most interesting findings of the program evaluation was acknowledgment that this program must be available to boys as well as girls. The plan in 1988 will focus on having one group for girls and one group boys in each of five school sites.

APPENDIX

COMPARATIVE STATISTICS BY SCHOOL SITE -1987-

The following section is composed of various tables which outline by school site the incidence and follow-up of specific medical, dental, and nutrition problems. These tables are presented to provide supporting data for the summary statistics which appear in the body of this report. This information may also be utilized in planning efforts directed toward maintaining and enhancing current efforts.

Examination of the tables reveals variations from site to site. A number of factors can contribute to these variations, for example, the enrollment of a large number of active versus recent settling-out farmworkers may increase the incidence of health related problems since the children may not receive ongoing care.

TABLE XV

TB TESTING (PPD) - RESULTS AND FOLLOW-UP
- 1987 -

		ABNORMALS IDENTIFIED		ABNORMALS FOLLOWED-UP	
	SCREENED	NUMBER	PERCENTAGE	NUMBER	PERCENTAGE
Brighton	1	0	0	NA	NA %
Fort Lupton	19	2	10.5	2	100
Kersey	19	0	0	NA	NA
Gilcrest	0	NA	NA	NA	NA
Longmont	31	1	3.2	1	100
Fort Collins	31	0	0	NA	NA
Fort Morgan	14	0	0	NA	NA
Burlington	0	NA	NA	NA	NA
Lamar	15	0	0	NA	NA
Rocky Ford	18	0	0	NA	NA
Pueblo	7	1	14.3	1	100
Alamosa	18	0	0	NA	NA
Grand Junction	0	NA	NA	NA	NA
Delta	4	0	0	NA	NA
TOTAL:	177	4	2.3 %	4	100 %

TABLE XVI

IMMUNIZATIONS

- 1987 -

SITE	IMMUNIZATION STATUS ASSESSED	CHILDREN IMMUNIZED	TOTAL # OF IMMUNIZATIONS GIVEN	# CHILDREN WITH RECORDS NOT AVAILABLE	# CHILDREN NEEDING IMMUNIZATIONS BUT CONSENTS NOT SIGNED
Brighton	174	1	3	0	0
Fort Lupton	37	8	15	31	7
Kersey	36	7	13	4	4
Gilcrest	0	0	0	0	0
Longmont	123	49	92	12	0
Fort Collins	108	18	29	8	5
Fort Morgan	112	10	19	8	1
Burlington	41	2	4	0	0
Lamar	33	12	24	2	1
Rocky Ford	122	13	28	0	2
Pueblo	16	1	2	0	1
Alamosa	108	26	46	6	9
Grand Junction	13	0	0	0	0
Delta	82	27	49	1	0
TOTAL:	1,005	174	321	72	30

TABLE XVII

VISION PROBLEMS - INCIDENCE/FOLLOW-UP
- 1987 -

SITE	# SCREENED	ABNORMALS IDENTIFIED		ABNORMALS FOLLOWED-UP*	
		NUMBER	PERCENTAGE	NUMBER	PERCENTAGE
Brighton	175	11	6.3 %	11	100 %
Fort Lupton	188	15	8.0	15	100
Kersey	155	8	5.2	8	100
Gilcrest	47	6	12.8	6	100
Longmont	232	31	13.4	31	100
Fort Collins	68	0	0	NA	NA
Fort Morgan	112	7	6.3	7	100
Burlington	40	11	3.6	11	100
Lamar	112	10	8.9	10	100
Rocky Ford	122	5	4.1	5	100
Pueblo	64	1	1.6	1	100
Alamosa	212	22	10.4	22	100
Grand Junction	75	3	4.0	3	100
Delta	82	6	7.3	6	100
TOTAL:	1,684	136	8.1 %	136	100 %

* This was reported as referrals to an outside provider (optometrist or opthalmologist) to determine need for or provide glasses. Some referrals were deferred for minimal vision abnomalities and for children who had glasses they would not wear.

TABLE XVII

HEARING PROBLEMS - INCIDENCE/FOLLOW-UP
- 1987 -

SITE	# SCREENED	ABNORMALS IDENTIFIED		ABNORMALS FOLLOWED-UP*	
		NUMBER	PERCENTAGE	NUMBER	PERCENTAGE
Brighton	175	8	4.6 %	8	100 %
Fort Lupton	188	5	2.7	5	100
Kersey	155	6	3.9	6	100
Gilcrest	46	2	4.3	2	100
Longmont	232	16	6.9	16	100
Fort Collins	67	1	1.5	1	100
Fort Morgan	112	0	0	NA	NA
Burlington	40	0	0	NA	NA
Lamar	112	8	7.1	8	100
Rocky Ford	122	32	26.0	32	100
Pueblo	65	2	3.1	2	100
Alamosa	213	14	6.6	14	100
Grand Junction	75	8	10.7	8	100
Delta	82	8	9.8	8	100
TOTAL:	1,684	110	6.5 %	100	100 %

* Reported as abnormals referred to an outside provider for follow-up diagnostic evaluation and care. Some referrals were deferred for children who had hearing aids they would not wear and children who moved before follow-up could be done.

TABLE XIX

ELEVATED BLOOD PRESSURE - INCIDENCE/FOLLOW-UP
- 1987 -

SITE	# SCREENED	ABNORMALS IDENTIFIED		ABNORMALS FOLLOWED-UP	
		NUMBER	PERCENTAGE	NUMBER	PERCENTAGE
Brighton	175	0	0 %	NA	NA %
Fort Lupton	188	0	0	NA	NA
Kersey	155	0	0	NA	NA
Gilcrest	46	0	0	NA	NA
Longmont	235	0	0	NA	NA
Fort Collins	68	0	0	NA	NA
Fort Morgan	112	0	0	NA	NA
Burlington	41	0	0	NA	NA
Lamar	112	0	0	NA	NA
Rocky Ford	122	0	0	NA	NA
Pueblo	65	0	0	NA	NA
Alamosa	213	0	0	NA	NA
Grand Junction	75	0	0	NA	NA
Delta	82	0	0	NA	NA
TOTAL:	1,689	0	0 %	NA	NA %

TABLE XX

SCOLIOSIS - INCIDENCE/FOLLOW-UP
- 1987 -

SITE	# SCREENED	ABNORMALS IDENTIFIED		ABNORMALS FOLLOWED-UP	
		NUMBER	PERCENTAGE	NUMBER	PERCENTAGE
Brighton	10	0	0 %	NA	NA %
Fort Lupton	22	0	0	NA	NA
Kersey	17	0	0	NA	NA
Gilcrest	0	NA	NA	NA	NA
Longmont	27	3	11.1	3	100
Fort Collins	8	1	12.5	1	100
Fort Morgan	22	0	0	NA	NA
Burlington	7	0	0	NA	NA
Lamar	10	0	0	NA	NA
Rocky Ford	0	NA	NA	NA	NA
Pueblo	6	0	0	NA	NA
Alamosa	17	0	0	NA	NA
Grand Junction	14	1	7.1	1	100
Delta	13	0	0	NA	NA
TOTAL:	173	5	2.9	5	100 %

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TABLE XXI
DENTAL PROBLEMS - INCIDENCE/FOLLOW-UP
- 1987 -

SITE	# SCREENED	ABNORMALS IDENTIFIED		ABNORMALS FOLLOWED-UP/ TREATMENT PROVIDED	
		NUMBER	PERCENT	NUMBER	PERCENT
Brighton	190	121	63 %	93	76 %
Fort Lupton	171	106	61	88	83
Kersey	152	85	56	75	88
Gilcrest	55	43	78	25	58
Longmont	276	154	55	123	79
Fort Collins	72	58	81	48	83
Fort Collins Preschool	24	16	66	12	75
Fort Morgan	113	80	70	70	87
Lamar	106	51	48	43	84
Rocky Ford	113	61	53	51	89
Pueblo	63	43	68	24	60
Alamosa	217	106	48	73	60
Grand Junction	78	40	51	40	100
Delta	63	49	77	30	61
TOTAL:	1,693	1,013	60 %	795	78 %

TABLE XXII
DESCRIPTION OF DENTAL FOLLOW-UP NEEDED
- 1987 -

SITE	# SCREENED	NEED ROUTINE DENT. CARE		NEED EMERGENCY DEN. CARE	
		NUMBER	PERCENT	NUMBER	PERCENT
Brighton	190	121	64 %	0	0 %
Fort Lupton	171	106	62	1	0.6
Kersey	152	81	53	4	3
Gilcrest	55	43	78	0	0
Longmont	276	146	52	8	3
Fort Collins	72	57	79	1	1
Fort Collins Preschool	24	16	66	0	0
Fort Morgan	113	78	69	2	2
Lamar	106	47	44	4	4
Rocky Ford	113	59	52	2	2
Pueblo	63	40	63	3	5
Alamosa	217	101	46	5	2
Grand Junction	78	33	42	7	9
Delta	63	48	77	1	2
TOTAL:	1,693	976	58 %	37	2 %

TABLE XXIII
DENTAL FOLLOW-UP - STATUS OF TREATMENT/REASONS FOR NO TREATMENT
- 1987 -

SITE	# CHILDREN NEED. CARE	STAT. OF DENT. TREAT. RECEIVED		REASON WHY ABNORMAL DID NOT RECEIVE TREATMENT				
		COMPLETE CARE	PARTIAL CARE	NOT REFER. (LOW PRIOR.)	NO CONS. FORM OR PAR. REF.	REFER. BUT MOV./NO TIME	POOR ATTENDANCE/ DROPPED OUT	MEDICAID OWN DDS
Brighton	121	79	14	0	4	2	22	0
Fort Lupton	106	87	1	10	0	3	5	0
Kersey	85	70	5	0	0	0	10	0
Gilcrest	43	20	5	3	0	5	7	0
Longmont	154	107	16	19	0	10	2	0
Fort Collins	58	42	6	0	1	9	0	0
Fort Collins Preschool	16	9	5	0	0	1	1	0
Fort Morgan	80	68	2	0	0	8	1	0
Lamar	51	37	6	0	0	7	1	0
Rocky Ford	61	53	6	0	0	2	0	3
Pueblo	43	24	0	2	2	12	0	0
Alamosa	106	60	13	30	4	12	1	0
Grand Junction	40	38	2	0	0	0	0	0
Delta	49	28	2	0	0	17	2	2
TOTAL:	1,013	722	83	64	11	88	52	3

TABLE XXIV
TYPE AND NUMBER OF DENTAL TREATMENT SERVICES IN DENTAL OFFICES
- 1987 -

SITE	DIAG.	PREVENTIVE	RESTORED SURFACES	CROWNS/SP. MAINTAINER	ENDO.	ORAL SURGERY	SEALANTS	TOTAL SERVICE
Brighton	858	190	295	4	10	17	402	1,776
Fort Lupton	791	171	373	3	12	17	287	1,655
Kersey	213	0	258	13	11	29	514	1,038
Gilcrest	141	30	75	0	1	3	37	287
Longmont	1,075	276	413	3	20	28	358	2,173
Fort Collins	221	0	242	7	8	7	56	541
Fort Collins Preschool	95	0	27	21	13	0	0	0
Fort Morgan	243	2	332	15	19	17	133	760
Lamar	123	0	195	30	16	30	21	415
Rocky Ford	169	4	217	11	4	5	70	480
Pueblo	75	99	122	9	6	3	102	416
Alamosa	307	0	431	32	20	38	26	854
Grand Junction	5	0	99	5	6	7	0	122
Delta	83	0	130	8	10	4	4	239
TOTAL:	4,399	772	3,209	161	156	205	2,010	10,912

TABLE XXV
COST* OF DENTAL SERVICES PROVIDED IN DENTAL OFFICES BY TYPE
- 1987 -

SITE	DIAG.	PREV.	RESTORED SURFACES	CROWN/SP. MAINT.	ENDO.	ORAL SURG.	SEALANTS	TOTAL
Brighton	$ 0	$ 0	$1,700	$ 100	$ 100	$ 100	$ 0	$ 2,000
Ft. Lupton	0	0	1,700	100	100	100	0	2,000
Kersey	300	0	1,797	300	50	100	514	3,061
Gilcrest	0	0	450	0	25	25	0	500
Longmont	0	0	6,500	300	300	400	500	8,000
Ft. Collins	790	0	4,191	576	215	50	212	6,034
Ft. Collins Preschool	300	0	242	687	195	0	0	1,424
Ft. Morgan	898	10	3,442	457	267	163	588	5,825
Lamar	616	0	3,427	1,372	685	323	97	6,520
Rocky Ford	611	80	2,000	294	60	53	355	3,453
Pueblo	335	558	1,218	273	110	45	360	2,899
Alamosa	1,172	0	4,586	1,293	1,021	726	135	8,933
Grd. Junct.	0	0	0	0	0	0	0	0
Delta	496	0	1,425	220	305	295	20	2,761
TOTAL:	$5,518	$ 648	$32,678	$5,972	$3,433	$2,380	$ 2,781	$53,410

* Includes cost from all sources except medicaid or private insurance.

TABLE XXVI
PREVENTIVE DENTAL SERVICES BY DENTAL HYGIENISTS
Prophylaxis, Topical Fluoride Application, Dental Counseling
- 1987 -

SITE	NUMBER SCREENED	RECEIVING PREVENTIVE SERVICES	
		NUMBER	PERCENT
Brighton	190	164	86 %
Fort Lupton	171	160	93
Kersey	152	131	86
Gilcrest	55	38	69
Longmont	276	250	90
Fort Collins	72	60	83
Fort Collins Preschool	24	21	87
Fort Morgan	113	97	85
Lamar	106	103	97
Rocky Ford	113	98	86
Pueblo	63	51	79
Alamosa	217	195	89
Grand Junction	78	75	96
Delta	63	52	82
TOTAL:	1,693	1,495	88 %

* In Dental Office

TABLE XXVII
NUTRITION PROBLEMS - INCIDENCE/FOLLOW-UP
- 1987 -

SITE	# SCREENED	NUT. PROB. INCIDENCE		NUT. PROB. FOLLOWED -UP	
		NUMBER	PERCENT	NUMBER	PERCENT
Brighton	175	36	21 %	33	92 %
Fort Lupton	188	17	9	17	100
Gilcrest	47	12	26	8	67
Kersey	155	36	23	34	94
Longmont	232	30	13	29	97
Fort Collins	68	23	34	22	96
Fort Morgan	112	23	21	19	83
Lamar	112	25	22	25	100
Rocky Ford	122	32	26	26	81
Pueblo	65	23	35	18	78
Alamosa	213	23	11	21	91
Grand Junction	75	4	5	4	100
Delta	82	9	11	8	89
Burlington	41	1	2	1	100
TOTAL:	1,687	294	17 %	265	90 %

TABLE XXVIII
BELOW NORMAL HEMATOCRIT - INCIDENCE/FOLLOW-UP
- 1987 -

SITE	# SCREENED	ANEMIA IDENTIFIED		ANEMIA FOLLOWED-UP	
		# ABNORMAL HCT	% ABNORMAL VS. SCREENED	# RECEIVING FOLLOW-UP	% ABN. VS. # FOLLOWED-UP
Brighton	175	8	5 %	8	100 %
Fort Lupton	188	2	1	2	100
Kersey	155	9	6	9	100
Gilcrest	47	3	6	3	100
Longmont	232	4	2	4	100
Fort Collins	68	3	4	3	100
Fort Morgan	112	6	5	6	100
Lamar	112	19	17	19	100
Rocky Ford	122	14	11	12	86
Pueblo	65	4	6	4	100
Alamosa	213	4	2	4	100
Grand Junction	75	0	0	NA	NA
Delta	82	4	5	4	100
Burlington	41	0	0	NA	NA
TOTAL:	1,687	80	5 %	78	98 %

TABLE XXIX
UNDERWEIGHT - INCIDENCE/FOLLOW-UP
- 1987 -

SITE	# SCREENED	UNDERWEIGHT IDENT.		UNDERWEIGHT FOLLOWED-UP	
		NUMBER	PERCENT	NUMBER	PERCENT
Brighton	175	8	5 %	6	75 %
Fort Lupton	188	3	2	3	100
Gilcrest	47	1	2	0	0
Kersey	155	11	7	2	18
Longmont	232	7	3	7	100
Fort Collins	68	3	4	3	100
Fort Morgan	112	0	0	NA	NA
Lamar	112	0	0	NA	NA
Rocky Ford	122	3	2	1	33
Pueblo	65	4	6	4	100
Alamosa	213	5	2	2	40
Grand Junction	75	1	1	1	100
Delta	82	1	1	1	100
Burlington	41	0	0	NA	NA
TOTAL:	1,687	47	3 %	30	64 %

Underweight is defined as weight for height at or below 5th percentile

TABLE XXX
OVERWEIGHT - INCIDENCE/FOLLOW-UP
- 1987 -

SITE	# SCREENED	OVERWEIGHT IDENTIFIED		OVERWEIGHT FOLLOWED-UP	
		NUMBER	PERCENT	NUMBER	PERCENT
Brighton	175	12	7 %	11	92 %
Fort Lupton	188	12	6	12	100
Gilcrest	47	8	17	4	50
Kersey	155	19	12	16	84
Longmont	232	19	8	18	95
Fort Collins	68	12	22	11	92
Fort Morgan	112	17	15	13	76
Lamar	112	13	12	13	100
Rocky Ford	122	17	14	13	76
Pueblo	65	12	18	7	58
Alamosa	213	9	4	7	78
Grand Junction	75	3	4	3	100
Delta	82	4	5	3	75
Burlington	41	1	2	1	100
TOTAL:	1,687	158	9 %	133	84 %

Overweight is defined as weight for height at or above the 95th percentile.

TABLE XXXI
"OTHER"* NUTRITION PROBLEMS - INCIDENCE/FOLLOW-UP
- 1987 -

SITE	# SCREENED	"OTHER" PROB. IDENTIFIED		"OTHER" PROB. FOLLOWED-UP	
		NUMBER	PERCENT	NUMBER	PERCENT
Brighton	175	8	5 %	2	25 %
Fort Lupton	188	9	5	3	33
Gilcrest	47	8	17	6	75
Kersey	155	6	4	6	100
Longmont	232	13	6	7	54
Fort Collins	68	5	7	5	100
Fort Morgan	112	0	0	NA	NA
Lamar	112	2	2	2	100
Rocky Ford	122	1	1	1	100
Pueblo	65	8	12	4	50
Alamosa	213	8	4	8	100
Grand Junction	75	0	0	NA	NA
Delta	82	0	0	NA	NA
Burlington	41	0	0	NA	NA
TOTAL:	1,687	68	4 %	44	65 %

" Other" includes hypertension, food allergies, dental problems, and feeding problems.

TABLE XXXII
HEALTH EDUCATION SERVICES BY NURSES
- 1987 -

SITE	CAMP and FAMILY NIGHT PRESENTATIONS		CLASSROOM ENCOUNTERS		STAFF IN-SERVICE	
	# SESSIONS	#PEOPLE	# SESSIONS	#PEOPLE	# SESSIONS	#PEOPLE
Brighton	2	33	8	180	1	7
Fort Lupton	1	10	20	509	0	0
Gilcrest	0	0	0	0	0	0
Kersey	1	5	7	102	0	0
Longmont	0	0	12	216	3	24
Fort Collins	1	10	4	90	0	0
Fort Morgan	0	0	0	0	0	0
Lamar	0	0	11	211	0	0
Rocky Ford	0	0	8	72	0	0
Pueblo	3	40	5	71	0	0
Alamosa	1	300	4	538	0	0
Grand Junction	3	25	2	19	0	0
Delta	0	0	5	143	1	17
TOTAL:	12	423	86	2,151	5	48

TABLE XXXIII
HEALTH EDUCATION SERVICES BY DENTAL HYGIENISTS
- 1987 -

SITE	FAMILY NIGHT PRESENTATIONS		GROUP ENCOUNTERS		STAFF IN-SERVICES	
	#SESSIONS	#PEOPLE	#SESSIONS	#PEOPLE	#SESSIONS	#PEOPLE
Brighton	1	135	15	315	0	0
Fort Lupton	0	0	6	130	0	0
Gilcrest	0	0	1	36	0	0
Kersey	0	0	4	110	0	0
Longmont	0	0	8	175	0	0
Fort Collins	4	110	5	123	0	0
Fort Morgan	0	0	6	93	0	0
Lamar	1	30	5	80	0	0
Rocky Ford	0	0	8	135	1	25
Pueblo	0	0	3	47	0	0
Alamosa	1	75	7	150	0	0
Grand Junction	1	30	22	327	1	6
Delta	0	0	24	228	0	0
TOTAL:	8	380	94	1,949	2	31

TABLE XXXIV
HEALTH EDUCATION SERVICES BY NUTRITIONISTS
- 1987 -

SITE	FAMILY NIGHT		GROUP ENCOUNTER		STAFF IN-SERVICES	
	#SESSIONS	#PEOPLE	#SESSIONS	#PEOPLE	#SESSIONS	#PEOPLE
Brighton	0	0	0	0	0	0
Fort Lupton	0	0	1	35	1	21
Longmont	0	0	2	75	1	25
Kersey	1	70	6	125	5	75
Fort Collins	1	15	8	96	5	58
Fort Morgan	1	30	4	78	3	40
Lamar	1	60	3	33	1	18
Rocky Ford	1	150	1	16	2	35
Alamosa	0	0	1	60	2	52
Pueblo	0	0	9	65	1	15
TOTAL	5	325	35	583	21	339

HEALTH DATA ENTRY FORM PART I

YEAR: 198__

CHILD'S NAME_____ NICKNAME_____

DATE OF BIRTH_____ SEX M F

LEGAL PARENTS NAMES_____ Are parents Spanish speaking only? Yes No

_____

IS EITHER PARENT USUALLY HOME DURING THE DAY?_____

CURRENT ADDRESS_____ TELEPHONE_____

DIRECTIONS_____

HOME BASE ADDRESS_____

MIGRANT STATUS 1 2 3 4 Year in which last moved for agricultural work: 19__

CHILD'S REGULAR DOCTOR_____

DENTIST_____

MEDICAID? Yes No OTHER INSURANCE? Yes No _____

HEALTH HISTORY Describe positive responses on the blank lines below; include name/address of doctor or clinic which can be contacted for further information.

YES/NO

(1) ____ V12.06 Has this child ever had tuberculosis, or ever had a positive reaction to a skin test for tuberculosis? ¿Ha tenido este niño/a tuberculosis, o una reacción positiva a la prueba de la piel para tuberculosis?

(2) ____ V12.4 Has he/she ever had any problems with his/her vision or with his/her hearing? ¿Ha tenido problemas ver u oir bien? (If yes, determine if uses or is supposed to use glasses (lentes) or a hearing aid (audífono/aparato de oido).

(3) ____ V12.41 Has he/she ever had epilepsy, or ever had a convulsion or seizure? ¿Ha tenido epilepsia, o ha tenido una convulsión o ataque?

(4) ____ V12.5 Has he/she ever had any kind of heart problem?, Has he/she ever had a heart murmur? ¿Ha tenido un problema con el corazón? ¿Ha tenido un murmullo o soplo del corazón?

(5) ____ V12.51 Has he/she ever had rheumatic fever? ¿Ha tenido fiebre reumática? (This must be a physician's diagnosis)

(6) ____ V14 Is this child allergic to any kind of medicine (including over-the-counter medicine)? Has he/she ever had serious reaction, that is, worse than mild fever or achiness, after getting any immunizations? ¿Es alérgico/a a alguna medicina? ¿Ha tenido una reacción seria despues de recibir alguna vacuna, es decir, mas seria que tener poco fiebre o sentirse poco adolorido?

(7) ____ V15.0 Does this child have allergies to food, plants, or animals? Does he/she have hay fever or asthma? ¿Es alergico/a a comidas, plantas, o animales? ¿Ha tenido fiebre del heno o asma?

(8) ____ Has this child ever had hepatitis? (Must be doctor's diagnosis) ¿Ha tenido este niño/a la hepatitis (o la piel amarilla)? Has anyone in your family had hepatitis in the last three months? ¿Ha tenido alguien en su familia la hepatitis durante los ultimos tres meses?

(9) ____ Is this child taking any medicines now, including medicines you can buy without a prescription? ¿Está tomando este niño/a alguna medicina ahora, inclusive medicinas que se pueden comprar sin una receta?

(10) ____ Has this child ever had any operations, or been in the hospital for any reason? ¿Ha tenido algunas operaciones, o ha estado en el hospital por alguna razon?

(11) ____ Has he/she had any serious illnesses, or serious injuries? ¿Ha tenido enfermedades serias, o heridas serias?

(12) ____ Do you have any special concerns about this child's health or about the way he/she is growing or developing? Are there any things this child has difficulty doing compared to other children his/her age? ¿Tiene Vd algunas preocupaciones sobre la salud de este niño/a, o sobre su creciendo o desarrollo? ¿Hay algo que su niño/a tenga más dificultad para hacer comparado a otras niños de su edad?

_____

_____

_____

_____

_____

_____

_____

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Signature of Recruiter_____

Date Health History Completed _____

Reporter ID_____ Funded Y___ N ___

Student #_____ Year: 198___

Date: _____ HEALTH DATA ENTRY FORM PART II GRADE_____

CHILD'S NAME_____ NICKNAME_____ DATE OF BIRTH_____

DID THIS CHILD ATTEND SCHOOL IN COLORADO THIS YEAR? Yes No
IF YES, NAME OF SCHOOL _____

IMMUNIZATIONS (Evaluate + update unless attended school in Colorado this year)
Enter date. Circle immunizations given during the summer program.

Initial IZ status: Complete ☐ Incomp ☐ Prov Comp ☐

Final IZ status: Complete ☐ Incomp ☐ Prov Comp ☐

V04.01	POLIO					
V04.2	MEASLES					
V04.3	RUBELLA					
V04.6	MUMPS					
V06.1	DPT					
V06.12	Td					
V03.8	HbPV					

Comments re immunization records_____

V74.1 DATE OF LAST SKIN TEST (PPD or TINE) FOR TUBERCULOSIS_____ RESULT_____

SCREENING						RE-SCREENING			
			DATE	A/N/U	VALUE	DATE	A/N/U	VALUE	FINAL OUTCOME
V72.0	90760	VISION			R L			R L	
V72.1	90760	HEARING							
V72.2	D0120	DENTAL SCREEN							
V72.2	D1120	DENTAL PROPHY							
V72.2	D1230	DENTAL FLUORIDE							
V72.80	90760	HEIGHT			in			in	
V72.81	90760	WEIGHT			lbs			lbs	
V74.1	86580	PPD							
V78.0	85014	HCT							
V81.1	90760	BP							
V82.81	90760	SCOLIOSIS							

DENTAL SERVICES

V72.2 D1350 DENTAL SEALANTS COMPLETED_____(date) PARTIALLY COMPLETED_____(date)
COMMENTS_____
DENTAL TREATMENT COMPLETED_____(date) PARTIALLY COMPLETED_____(date)
COMMENTS_____

SIGNIFICANT ACTIVE PROBLEMS If an abnormal screening was noted on the SCREENING section, do not repeat it here unless the abnormality was the result of another underlying problem which needs to be noted.

DATE	DIAGNOSIS	ICD-9 CODE	TYPE (A/C)	STATUS (U/R)	CPT CODE	A/N/U	PLAN/OUTCOME

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MIGRANT EDUCATION
SUMMER SCHOOL HEALTH PROPOSAL
1988

PROPOSAL TO: COLORADO DEPARTMENT OF EDUCATION
MIGRANT EDUCATION PROGRAM

PROPOSAL FROM: COLORADO DEPARTMENT OF HEALTH
MIGRANT HEALTH PROGRAM

PROPOSAL FOR: MIGRANT EDUCATION HEALTH PROGRAM
1988

February, 1988

COLORADO DEPARTMENT OF HEALTH/MIGRANT SUMMER HEALTH PROGRAM
PROPOSAL
April 1, 1988 - September 30, 1988
TOTAL GRANT - $110,000
TO SERVE APPROXIMATELY 1,800 MIGRANT SCHOOL AGE CHILDREN

I. INTRODUCTION

For the past 15 years the Colorado Migrant Health Program and the Colorado Migrant Education Program have worked cooperatively to provide comprehensive health services to migrant summer school enrollees. We propose to continue this effort in 1988.

The 1987 Migrant Education Health Program Report detailed the activities of the 1987 program. This included highlights of the 1987 program, staffing patterns, health status of the students, and health education activities.

Looking ahead to 1988, major program goals and policies will remain unchanged. The following will be areas of focus:

1. According to information collected during the past several years, usage of the MSS-HEC health education curriculum and health education activities in general have declined. In 1988, a major emphasis will be placed on discussing with individual migrant education directors their committment to health education. Migrant Health and Migrant Education Program staff will work with migrant education directors to devise a plan for health education that can best be incorporated into the local school curriculum. In addition, program staff will be exploring alternative ways of providing migrant students with health education and health promotion activities (e.g., PASS program, use by year-round migrant tutors).

2. In 1988 the Colorado Migrant Health Program will continue the expanded and formalized relationship with the state-level Migrant Education Parent Advisory Council as well as several local Migrant Education PAC's in order to provide opportunity for an enhanced level of consumer participation in the development and operation of Migrant Health Services in Colorado. Areas of inquiry include patient fees, staffing patterns, times and locations of services, and satisfaction with services. Year-round area and seasonal staff will meet with local PAC's; Colorado Migrant Health Program central office staff will meet with the state PAC.

3. A major philosophy of the Colorado Migrant Health Program is that parents should be involved in the health care and treatment of their children. In addition, parents need instruction on how they can serve as positive role models and health promotors for their children. In 1987, however, only 3% of all encounters occurred in the homes of migrant education students. Therefore, a major goal in 1988 will be directed toward more encounters taking place with parents of migrant

education students. Migrant Health Program staff will meet with local migrant education directors and principals to negotiate how this will best be achieved (e.g. planning that the nurse will not be at school one to two afternoons per week in order to be able to spend those afternoons and evenings visiting families in their homes). Negotiation will also take place for the provision of translators to assist non-Spanish speaking health providers during these interactions.

II. OVERVIEW - COLORADO MIGRANT HEALTH PROGRAM

The Colorado Migrant Health Program is responsible for assuring the maintenance, promotion and protection of the health status of Colorado's migrant and seasonal farmworker population.

The staff provides health services year-round through decentralized staff and contractual relationships with local health care delivery systems. Interdisciplinary health teams composed of nurses, nurse practitioners, dental hygienists, nutritionists, dental students, nursing students, and child health associate students are fielded yearly during the migratory season in high-impact areas (i.e., San Luis Valley, Arkansas Valley, Mesa, Delta and Montrose Counties on the Western Slope, North Central and Northeastern Colorado.) Treatment services are provided by more than 200 local physicians, dentists, pharmacists and medical specialists throughout the state with whom the program maintains referral agreements.

A special feature of the program is the relationship maintained with the Colorado Department of Education - Migrant Education Program. Through annual contracts the Migrant Health Program recruits, selects, orients and supervises health practitioners to provide health services in all twelve Migrant Education summer school sites. Services include: comprehensive medical assessment and treatment as required, dental assessment and treatment as indicated, preventive dental services (topical fluoride and sealants), health education, day-to-day nursing services, and medical records management.

Principal funding for the Migrant Education Health Program is provided by the Department of Health and Human Services (DHHS) and a contract with the Colorado Department of Education - Migrant Education Program.

In order to avoid fragmentation of effort and duplication of services, the Colorado Migrant Health Program coordinates plans and activities with the following organizations and agencies:

Internal

Nutrition Services/WIC
Handicapped Childrens Program
Family Planning
Disease Control/Epidemology
Consumer Protection
Community Nursing
Water Quality Control
Laboratory Services
E.P.S.D.T.
Dental Health

External

Colorado Department of Education
University of Colorado Health Science Center
School of Nursing
Dentistry
Preventive Medicine
Child Health Associate Program
Colorado Medically Indigent Program
Colorado Maternity Program
Colorado Migrant and Rural Coalition
Coloado Social Legislation Committees
Colorado Medical Society
Larimer County Health Department
Plan de Salud de Valle, Inc.
Sunrise Community Health Center, Inc.
Valley-wide Health Services, Inc.
La Clinica del Valle, Inc.
Pueblo Community Health Center, Inc.
Colorado Division of Vocational Rehabilitation
Colorado Rural Legal Services
Rocky Mountain SER
Weld County Headstart
Bueno Center for Multicultural Education (HEP)
Otero Community College (Migrant Headstart)

200 local health care providers
17 local hospitals

The goal of the Migrant Health Program is to have available in rural Colorado comprehensive health care delivery systems which are appropriate to, and accessible by, migrant and seasonal farmworkers. Bilingual capability, adjusted hours of practice, and sliding-fee scales are essential elements of these systems. In support of this goal, the major program objective of the 1980's is to integrate services for migrant and seasonal farmworkers into local health care delivery systems that are currently available.

III. AGENCY CAPABILITY

For the past 15 consecutive years, the Colorado Migrant Health Program has provided a comprehensive health program to enrollees in migrant summer schools through contractual agreement with the Colorado Department of Education - Migrant Education Program. In late 1980, a U.S. Office of Education audit team identified the Migrant Education Health Program as a major exemplary facet of the total project.

The Colorado Migrant Health Program is both willing and eager to continue this high-quality effort in 1988 within the context of current budget constraints.

IV. STATEMENT OF NEED

It is anticipated that there will be approximately 1,800 children of migrant farmworkers enrolled in ECIA migrant education summer schools in Colorado during the 1988 high-impact migratory season. These children represent the principal "high-risk" portion of the total migrant and seasonal population in Colorado. An additional several thousand children are enrolled in regular year school programs.

Not only do children of migrant farmworkers face the typical diseases and health problems associated with childhood, but in addition, they confront numerous health problems and risks associated with their migratory lifestyle and the environmental hazards of agricultural work (the third most hazardous occupation in the U.S.).

Data gathered from the 1987 Migrant Education Health Program shows that although there have been gradual improvements in the overall health status of migrant children, most of their health indices continue to lag behind those for Colorado school children in general. This reflects the greater need for health services that continues to exist for migrant children. For example:

- The prevalence of abnormal vision among migrant school children ws 8.1% in 1987. This compares to the 6.0% prevalence rate observed among all Colorado school children.

- In 1987, 6.5% of Colorado migrant children were determined to have abnomral hearing. This is more than double the incidence of 2.8% observed for all Colorado school children in 1986-87.

It is clear that maximum educational achievement will be hindered by undiagnosed and untreated health problems. While it is axiomatic that children in poor health will not achieve their full educational potential, it is also critically important to view the development of healthful lifestyles and health practices as essential elements of each child's educational experience.

There is a need, therefore, for a comprehensive health program in the schools that addresses the unique needs of migrant children, that is integrated into the educational program and that is linked in a systematic fashion to a broad variety of health care providers in each community.

NOTE: Specific information and health statistics related to the actual health problems identified during the 1987 Migrant Education Program are included in the 1987 Migrant Education Health Program Annual Report which has been distributed statewide.

V. COST-EFFECTIVENESS

Although both the Department of Education and the Department of Health place primary emphasis on the delivery of high-quality services to their respective clientele, a secondary but equally important objective is to maximize the benefit derived from each dollar expended in this effort.

There are a number of cost-effective measures which deserve special mention:

A. Dental Services

In 1988, a total of 22-25 dental students and graduates will be placed in local dental offices in close proximity to Migrant Education Summer School sites. Working under the preceptorship of local dentists, the cost to the program for dental services is only one-half the usual and customary fee which is charged to other dental patients. In 1988, it is estimated that the value of dental treatment services offered will be approximately $145,000, while the cost to the Migrant Education Health Program will be approximately $11,616 (treatment and dental student stipends).

B. Use of Existing Resources

Through Area Coordinators employed by or under contract to the Migrant Health Program, extensive, annually updated inventories of locally available health resources are maintained. It is only after exhausting these other resources that program monies must be spent for services to the migrant child.

C. Utilization of Student Health Personnel

In addition to dental students, the Migrant Health Program also recruits, selects, orients and supervises a number of nursing, dental hygiene and child health assoicate students. Working under very close supervision, these students (at no cost to the Migrant Education Program) provide a full range of services to the migrant student.

The 1987 Migrant Education Health Program report provided a thorough cost-benefit analysis which delineated clearly all costs associated with the health program and the total value of services (benefits) derived.

VI. PROPOSED SOLUTION

It is proposed that the Colorado Department of Education, ECIA Migrant Education Program, contracts with the Colorado Department of Health, Migrant Health Program, to develop and implement a health program for the migrant summer schools and evening adolescent programs.

A. SUMMER PROGRAM

The services to be provided under this contract will represent a continuum of care to include screening, physical assessment and detection of existing health problems, referral for diagnosis and treatment of abnormalities, case management/follow-up, preventive and

health promotion/health maintenance services, and health record management. The proposed program will be coordinated with day-to-day educational activities and will involve and encourage participation of parents and other family members.

1. Services to be Provided

a. Screening and Physical Assessment

Utilizing screening procedures as outlined in physical asessment protocols, all interdisciplinary team members will participate in the following screening procedures:

(1)	vision	(4)	B/P
(2)	hearing	(5)	hematocrits
(3)	height/weight	(6)	scoliosis

The purpose of screening and physical assessment is to provide for early detection of abnormalities so that treatment services may be initiated and completed in advance of families leaving the area.

b. Referral for Diagnosis Confirmation/Treatment

Utilizing the services of more than 200 private practitioners with whom the Migrant Health Program maintains ongoing working relationships, all migrant summer school enrollees for whom abnormalities are discovered during the screening/physical assessment process will be offered treatment as indicated and financially feasible.

In addition, these resources will also be available for treatment of acute medical/dental problems as they are identified during the course of the regular school program.

c. Case Management/Follow-up

In coordination with the Migrant Education director/principal and migrant education nurse, each child for whom a health problem is identified in a screening will receive follow-up services, including parent contact to:

(1) assure compliance with prescribed regimens and medications,
(2) assure that necessary return visits are appropriately scheduled and adhered to, and
(3) assure that parents are adequately informed of their child's diagnosis and involved in ongoing needs for treatment.

d. Dental Services

Nationally, dental disease has been identified as the number one chronic health problem in children and as the number two reason for school absences. 95% of school age children will experience tooth decay. Oral infections are systemic. They frequently cause stomach aches, ear aches, and other painful conditions in children that are not always identified as dental in origin. Significantly, dental disease will not correct itself. Untreated, it will lead to serious dental diseases and eventually to loss of teeth. It is additionally significant that dental diseases are, for the most part, preventable; dental diseases are always treatable.

Specific dental services will include the following:

(1) Identification of Needs

Children enrolled in the Migrant Education summer schools will receive a dental screening. Caries, periodontal disease, malocclusion, speech defects and adverse oral habits will be identified. From this screening information an individual-specific dental plan will be developed.

(2) Treatment of Identified Needs

All children needing emergency dental treatment will be referred to local dental offices for care. Other children needing care will be prioritized and referred based upon available time, both with the dentist and the patient's time in the area. For example, all children with caries in first permanent molars are referred because these teeth must last a lifetime.

In an effort to maximize the amount of care provided while migrants are in the area, dental screening is conducted as soon as school opens. Dental treatment begins the next day and continues until school closes. Time is set aside in dental offices for migrant children between 9:00 a.m. and 3:00 p.m. daily. Protocols state that quality treatment will be completed on all children as money and time permit.

(3) Prevention

Most children will receive classroom dental health education and individual instruction.

A majority of the children will receive a dental prophylaxis (cleaning) and topical fluoride application at the school. Fluoride combines with the teeth, making them stronger and less susceptible to dental decay.

Diet counseling as it relates to dental health is given in coordination with the migrant education nutritionist and dental students.

The dental pit and fissure sealant services will be placed in all sites. A sealant retention study will be conducted to assure quality.

e. Nutrition Services

Over the past several years medical literature has suggested that migrant children have significantly more nutritional problems and deficiencies than non-migrant children. Data collected from the 1987 Migrant Education Health Program seems to be consistent with this statement.

Symptoms of a nutritional deficiency such as anemia are fatigue, frequent illness, poor appetite and short attention spans. Consequences of prolonged anemia may result in decreased growth and development potential and increased susceptibility to infections.

Other nutrition problems such as growth failure, overweight, and failure to thrive have equally devastating results in terms of the child's learning potential.

The primary focus of the summer nutrition program is to provide direct counseling to children and families where nutritional deficiencies are found. As part of the nutrition management of these problems, it is important to assess dietary intake, to determine parent/child motivation for changing eating behaviors, and to provide individual dietary counseling and follow-up.

Secondary services which can be provided in the school setting include: a) assistance in health screenings, b) inservice training to teaching and food service staff, c) assistance for teachers in using nutrition classroom curriculum plans, and d) nutrition education at parent/family nights.

f. Supportive Services - Health Aides

In order to facilitate the provision of health services, health aides will be required in each site according to the chart on page 11. Aides will be bilingual and will work under the supervision of the nurse, nutritionist and/or dental hygienist. The aides will assist in screening processes, recording selected patient information, providing transportation when necessary, coordinating times for medical and dental appointments, and providing translation when needed. Health aides must be provided and paid for by local BOCES or local district budgets. It is requested again this year that health aides participate in the CMHP summer team orientation sessions.

g. Health Education Services

In 1979, the U.S. Department of Health Education and Welfare released the Surgeon General's Report on Health Promotion and Disease Prevention (Healthy People). The central theme of the report is that the health of this nation's citizens can be significantly improved through actions that individuals can take themselves. Not only do these personal decisions influence the length of people's lives and their capacity to enjoy it, but in addition, these decisions also have major impact on the long-term overall cost of health care services.

In addition to the obvious potential for a positive impact on the health status of a population as a direct outgrowth of education and preventive efforts directed toward dental and nutrition issues as described above, there are a number of other education/health promotion topics which are of importance to this special population.

During the 1988 health program, it is proposed to direct major health education efforts into the continuation of the health education kits designed in 1982 and implemented in 1983.

2. Proposed Summer Staffing

The staffing pattern required in support of the services described above is as follows:

17 Migrant Education Nurses
4 Nutritionists
20 Dental Hygienists/Dental Hygiene Students
24 Dental Students/Graduates
12 Nursing Students

We propose to distribute these 77 health providers as per the following chart. Note that many providers will play active roles in two or more school settings, as well as other migrant programs locally.

It is important to note that although the ECIA Migrant Education Program will benefit from each of these 77 providers, funding is requested for only 25.1 positions. This figure is composed of 17 nurses, 25% of 4 Nutritionists (1.0), 70% of 3 dental hygienists (2.1) and 5 dental students.

PROPOSED STAFFING PLAN *
MIGRANT EDUCATION HEALTH PROGRAM
- 1988 -

SCHOOL SITE	NURSES	NUTRITIONISTS	DENTAL HYGIENISTS	DENTAL STUDENTS
Fort Lupton	x	x	x	x
Brighton	x	x	x	x
Longmont	x	x	x	x
Fort Collins	x	x	x	x
Greeley	x	x	x	x
Fort Morgan	x	x	x	x
Lamar	x	x	x	x
Burlington				
Rocky Ford	x	x	x	x
Pueblo	x	x	x	x
Alamosa	x	x	x	x
Delta	x		x	x
Grand Junction	x		x	x

* Four regional nutritionists will be working with the health teams.

* See page 11 for proposed staffing of school health aides.

PROPOSED STAFFING - HEALTH AIDES
MIGRANT EDUCATION HEALTH PROGRAM
- 1988 -

SCHOOL SITE	AIDES	TOTAL FTE
Fort Lupton	Nursing/Nurtriton Dental Transportation	2-3
Brighton	Nursing/Nutrition Dental Transportation	2-3
Longmont	Nursing/Nutrition Dental Transportation	2-3
Fort Collins	Nursing/Nutrition Dental	1-2
Greeley	Nursing/Nutrition Dental Transportation	2-3
Fort Morgan	Nursing/Nutrition Dental	1-2
Lamar	Nursing/Nutrition Dental	1-2
Rocky Ford	Nursing/Nutrition Dental	2-3
Pueblo	General Transportation	1-2
Alamosa	Nursing/Nutrition Dental Transportation	2-3
Delta	Nursing/Nutrition Dental	1-2
Grand Junction	Nursing/Nutrition Dental	1-2
	Total:	19-30

NOTE: The ranges provided above are based upon professional judgement and analysis of past practices. These positions must be approved by the state agency and provided by local BOCES and local districts.

3. Role Responsibilities

At the onset it must be acknowledged that the success of the health component of the Migrant Education Summer School program will be possible only if both health providers and education providers recognize and operate from a position of interdependence.

The following role responsibility statements are intended to provide clarification of how this interdependence may be expressed.

a. Responsibilities of Nursing, Dental, and Nutrition Consultants, Colorado Department of Health, Migrant Health Program

(1) Recruit, hire and orient registered nurses, nutritionists, and dental staff to provide the health program in each school.
(2) Provide professional supervision of the ECIA, Chapter 1, Migrant School Health Program (nursing, dental, and nutrition components).
(3) Establish liaisons with local providers for health care services.
(4) Process and pay medical, dental and pharmacy authorization for service vouchers.
(5) Jointly coordinate with the Colorado Department of Education to provide pre-season staff inservices.
(6) Provide summer health staff with necessary supplies to deliver school health services.
(7) Evaluate the Summer Migrant School Health Program, prepare the year end summer school health services report, and submit evaluation to CDE by December 31, 1987.
(8) Negotiate with the UCHSC for Health Science Students' participation in the program.
(9) Develop joint protocols on interrelationships of health component.

b. Responsibilities of The Colorado Department of Education - Migrant Education Program Supervisor (Ernie Maestas)

(1) Provide the location and dates of operation for the summer migrant programs to the Colorado Department of Health to facilitate recruiting purposes.
(2) Provide current information on MSRTS for health program.
(3) Coordinate joint presentation of health program to local directors.
(4) Assist in problem solving during the season and provide feedback at the end of the program.

c. Responsibilities of Local Program Director/Principal

(1) Understand and support the goals and objectives of the health component as described in the interagency contract.
(2) Participate in pre-program planning sessions with Migrant Health Program staff to adapt the health component to the specific site and negotiate modification if necessary.
(3) Assume general responsibility for the health program on site, including developing line-staff relationships to insure that administrative direction is provided in his/her absence and communicating such relationships to all staff members.
(4) Arrange adequate space and equipment for health and dental offices. This includes use of a telephone (privacy is essential when discussing a patient's health with parents, providers, etc.), audiometer for hearing testing, scale (which has been calibrated within the last year), and miscellaneous paper, pens, stapler, tape, etc.
(5) Orient health staff to school program. Provide time for health staff to orient school staff to health program.
(6) Coordinate and approve health screening dates especially for the first week of school.
(7) Assure that health records are available at the beginning of school and as students enroll. This includes an up-to-date Health Data Entry Form and signed parental consent.
(8) Assure that Records Clerks provide migrant education nurses with names of those students continuing from the regular school year who need follow-up of health conditions.
(9) Inform health team of school schedules (e.g., arrival and departure times of buses, lunch schedule) and special school activities (e.g., swimming, field trips) that might interfere with health-related activities such as dentist and doctor appointments. Assist in coordination of medical, dental, and health education activities around school activities.
(10) Integrate the health team into the activities of the school (e.g., staff meetings, family nights). Discuss expectations of health staff's participation in field trips and other school activities.
(11) Provide health/dental/transportation aides as discussed on page 11 and as negotiated with the Migrant Health and Migrant Education Program staff. Aides must be bilingual and be mature enough to deal with sensitive health problems and confidential health information.
(12) Assist health team in coordination of health services and health education for families. This may include the participation of the health team in school family nights and/or evening health clinics at the school.
(13) Assist health team in coordinating home visits. This includes allowing scheduled time away from the school and arranging for translation assistance as needed.

(14) In coordination with the Migrant Health and Migrant Education Program staff, identify mechanism for providing health education. Assist in coordinating health education activities between nurse, nutritionist, dental hygienist, and teachers. This includes daily toothbrushing.
(15) Discuss with migrant education nurse the children who will need follow-up after the summer health program. Assist in coordinating follow-up with appropriate personnel (e.g., regular year school nurse, migrant education recruiter, local health providers, etc.)
(16) At end of summer, assure completion of Health Data Entry Form and reported health information.
(17) Arrange funding for nutrition food supplies to be used in classrooms with the health education units.
(18) Support the nutrition program with food service staff. Assist coordination of food services staff and nutritionists by arranging time during local school orientation for cooks and nutritionists to meet.
(19) Assure compliance of other school staff members with responsbilities as they appear in the health contract.
(20) Arrange and participate in exit interview with the health team.

d. <u>Responsibilities of Teachers and Teachers Aides (in Relation to the Health Program)</u>

(1) Teachers will be invited to participate in the health screening and encouraged to assist when indicated (e.g., an unusually anxious child, the very young).
(2) Meet with principal/director and health team during the first week of school to agree upon schedule for on-going health education activities in the classroom.
(3) Advocate with children good health principles (model positive attitude towards nutrition, dental health and general health).
(4) Participate in identification, referral and follow-up of health problems in children by frequent communication with health team.
(5) Discuss with health staff the best arrangements for health appointments and schedules in that particular classroom.
(6) Assist in triaging health problems.

e. <u>Responsibilities of Migrant Education Recruiter/Contract Personnel (in Relation to Health Program)</u>

(1) Provide health team with <u>completed</u> health data entry form and enrollment form on or before first day of program and as students enroll.
(2) Assist in giving information to families regarding the WIC program, area migrant health resources, and other community resources.

(3) As approved and assigned by the principal, assist team members with home visits to the extent possible.

f. Responsibilities of Migrant Education Records Clerk (in Relation to the Health Program)

(1) Provide updated enrollment lists and withdrawal information on students to the health team on a day-to-day basis. This should include health data entry intake forms for new students as they arrive.
(2) Provide health team with MSRTS health record as soon as it is received at the school.
(3) Cooperate with nurse in utilization of health data entry form.
(4) Provide coordination between the migrant nurse and the MSRTS terminal operator when health record problems occur.
(5) Act as general resource to health team on MSRTS.
(6) Provide Migrant Education Nurse with list of students continuing from regular year school program who require medical follow-up.
(7) Supply migrant nurse with any additional health records or information on enrolled children (e.g., immunization records, special problems or follow-up from regular school).
(8) Submit health data for submission to the MSRTS.

g. Responsibilities of Migrant Education Food Service Staff (in Relation to the Health Program)

(1) Assist in providing requested kitchen equipment and supplies for classroom education sessions (e.g. measuring cups, knives, bowls, spoons, etc.) to the extent possible.
(2) Coordinate with nutritionist and principal in assuring that individual nutrition needs of children are met (e.g. handicapped children are given food which is cut appropriately).
(3) Advocate for good nutrition by encouraging children to try new foods.

4) Discuss with dental staff on a daily basis the special needs of children receiving dental treatment (e.g. soft food following extractions, delay in eating if mouth is still anesthesized to avoid chewing the lip or cheek, no breakfast if a child is to have nitrous oxide or other anesthesia).

h. Responsibilities of Migrant Education Health Aides

(1) Assist in all health record keeping as assigned by nurse, (e.g., filing, completion of identifying information on patient encounter, etc).

(2) Assist in health screening, rescreening and health related information (e.g., student flow, recording as instructed, etc.).
(3) Provide transportation to and from medical and dental appointments.
(4) Provide oral and written translation for non-bilingual health team members at the school site and during home visits with team members regarding medical and dental care (e.g., evening home visits with health team members).
(5) Assist with fluoride programs and toothbrushing.
(6) Provide information to parents as assigned by health team members.
(7) Complete other duties as assigned by health team members.

i. Responsibilities of School Nurse

(1) Provide health services, including assessment, referral, health education and follow-up for children. Provide overall summary of health screening to teachers and principal. Relay specific follow-up needs of child to involved teacher and principal.
(2) Serve as health team coordinator for site. Arrange at least weekly team meetings (including school/center staff as needed) for planning and coordinating activities in coordination with principal/director.
(3) Coordinate activities with other health team members, to assure non-duplication of services and minimal disruptions of normal schedules (e.g. screening). Act as liaison between other health team members and local school staff, including directors and teachers.
(4) Communicate all health schedules and program activities to the principal and staff.
(5) Control assigned medical care budget.
(6) General responsibility for inclusion of nutrition services on site including:
   a) overall responsibility to assure that nutritionist has list of nutrition-related problems for follow-up,
   b) assurance that patient records include nutrition notes,
   c) assurance of inclusion of nutrition information on MSRTS, and
   d) integrating nutrition information and education on home visits to patients and including nutritionist on visits as needed.
(7) Coordinate home visits with health team (i.e., which member is most appropriate, what information must be relayed) and assures completion of encounter form. Informs principal of who needs home visits, date and time of visit, and need for translation service.
(8) Provide appropriate referrals to: 1) the nutritionist for individual counseling, and 2) the WIC program.

(9) Provide Colorado Department of Health staff with any materials and lesson plans developed and used during the summer program.
(10) Be available on a regualr basis for consultation with staff regarding the health status of individual students.

(11) Provide MSRTS health record information to the records clerk.
(12) Observe the administrative rules, regulations and line staff relationships as they exist and as may be defined in the interests of efficient and effective school operation.
(13) Provide list of students, health care provided and needed follow-up to principal at end of school term.
(14) Inform Migrant Health Central Office of unresolved interdisciplinary team conflicts which are interfering with the delivery of health care.

j. Responsibilities of Colorado Department of Health Summer Nutritionist, With the Coordination of the School Nurse

(1) Assist in health screening and provide assessment and follow-up care to children with special nutrition needs and problems.
(2) Assist teachers on a limited basis in integrating nutrition and health information into the core curriculum. Assist in evaluating nutrition curriculum.
(3) Participating in family night activities relating to nutrition and health.
(4) Provide culturally appropriate health education and nutrition resource materials for all age groups.
(5) Inform Central Office of unresolved inter disciplinary team conflicts which are interfering with the delivery of health care.

k. Responsibilities of The Dental Staff, with the Coordination of the School Nurse

(1) Provide dental inservice education to summer school and health staff.
(2) Provide dental screening to children enrolled in the program.
(3) Provide remedial dental treatment for those children identified in need.
(4) Provide preventive dental services, including classroom education, dental prophylaxis, topical fluoride application, plaque control instructions and sealants.
(5) Assist in parent night activities and appropriate dental programs for night/teen programs.
(6) Provide for parental involvement through the mechanism of home visits.

(7) Provide Colorado Department of Health staff with any materials and lesson plans developed and used during the summer program.
(8) Report to the school nurse children whose schedules need to be coordinated or who have special needs.
(9) Inform Migrant Health Central Office of unresolved interdisciplinary team conflicts which are interfering with the delivery of health care.

1. Responsibilities of All Members of the Migrant Health Team

(1) Participate in local orientation.
(2) Participate in preservice and inservice training sessions upon request of principal/director.
(3) Inform principal/director of medical and dental appointments.
(4) Coordinate home visits with health aides and recruiters (as appropriate).

4. Conflict Resolution

Professional and program conflicts on the local level will be jointly resolved between Colorado Department of Health, Migrant Health Program and Colorado Department of Education, Migrant Education Program in the following manner:

a. Locally by the local program principal and school nurse.

b. If unresolved, the local Migrant Education Program Director and the discipline coordinator involved.

c. If unresolved, the problem is to be reported to the state Supervisor, Migrant Education Program, Department of Education and the Director of the Migrant Health Program.

5. Reporting and Accountability

In order to assure the Colorado Department of Education Migrant Education Program that services delineated in this proposal are in fact delivered and the expenditures are appropriate to the agreed-upon budget figures, the following reporting and accountability standards are proposed:

(1) All health personnel will be expected to keep primary documents on services they provide to and in behalf of the school-age child, i.e., clinic rosters, individual patient encounter forms.

(2) MSRTS health records and health data entry forms will be completed prior to exit of the summer health team.

(3) All financial management activities will be in accordance with acceptable accounting practices.

(4) Data and summary reports will be provided by the Migrant Health Program, Colorado Department of Health. An evaluation report detailing activities and outcomes of the 1988 effort will be completed and delivered by December 31, 1988.

(5) The Colorado Department of Health will provide final status expenditure reports to the Colorado Department of Education on December 31, 1988.

(6) Protocols have been developed in each health area and will be used to assure prompt, proper referral to and appropriate utilization of medical and dental services.

(7) All Migrant Health Program central office discipline consultants will cooperatively provide ongoing evaluation of health activities and serve as consultants to the Colorado Department of Education and local districts for migrant health.

(8) The Department of Education will solicit consumer reponse and determine the level of satisfaction with services provided through parent involvement activities in each school site.

(9) Program data will be analyzed to assure that treatment is appropriate. Specifically, the quantity and quality of services will be measured and the percentage of identified abnormal conditions treated will be documented. Evaluations will be solicited from participating school and health personnel.

6. Request from Colorado Department of Education

In order to field the health program as described in this proposal, a total of $110,000 is required from the Colorado Department of Education.

The following budget presents the amount of financial resources required from the Colorado Department of Education, Migrant Education Program, in order to provide the services described.

ECIA
MIGRANT EDUCATION SUMMER SCHOOL
HEALTH CARE PROGRAM
1988
BUDGET

(Includes estimated $6,000 Waived Indirect Costs)

I.	PERSONNEL		
	A. Migrant Education Nurses 17 Nurses x 9 weeks each x $350/week		$ 53,550
	B. Migrant Education Nutritionists 25%-4 nutritionists x 9 weeks x $350/wk.		$ 3,150
	C. Migrant Education Dental Hygienists 70%-3 dental hygienists x 9 weeks x $350/wk.		$ 6,615
	D. Migrant Education Dental Students 5 dental students x 4 weeks x $300/wk		$ 6,000
		Total Personnel	$ 69,315
II.	STAFF TRAVEL		
	A. Nurses	$ 1,500	
	B. Dental Hygienists	1,000	
	C. Nutritionists	450	
	D. Dental Students/Grads.	800	
		Total Travel	$ 3,750
III.	STAFF ORIENTATION		$ 3,000
IV.	SUPPLIES		
	A. Medical	800	
	B. Dental	646	
	C. Nutrition	$ 100	
		Total Supplies	$ 1,546

V.	PATIENT CARE			
	A. Medical		$ 14,000	
	B. Dental		$ 6,524	
	C. Pharmacy		$ 2,000	
			Total Care	$ 22,524
			Total Direct Expenses	$ 100,135
VI.	INDIRECT			
	A. On-Site	(19.3% x $ 29,112) =	$ 5,619	
	B. Off-Site	(16.0% x $63,315) =	$ 10,130	
	C. Flow-Thru	(1.5% x $ 7,708) =	$ 116	
		Indirect Cost	$ 15,865	
		Waived Indirect Cost	- 6,000	
		Total Indirect Cost:		$ 9,865
		GRAND TOTAL:		$ 110,000

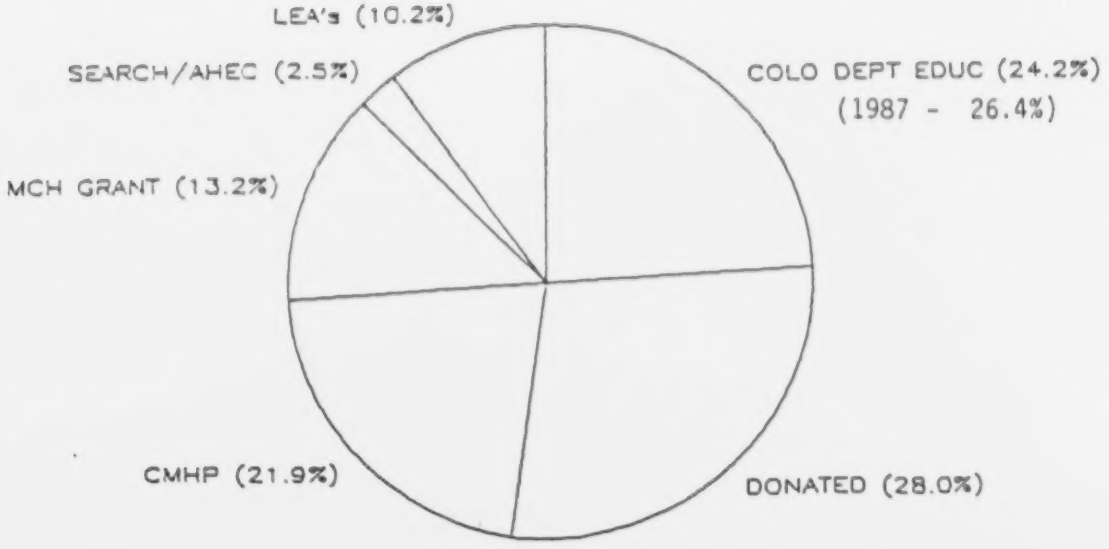
BUDGET SUMMARY
- 1988 -

	Budget Category	Total Amt. Required For Migrant Educ. Health Program	Request To CDE	Request % Of Need
I.	Personnel	$ 234,195	$ 69,315	29.6 %
II.	Travel	10,400	3,750	36.0
III.	Operating Costs	16,400	4,546	27.7
IV.	Patient Care	168,608	22,524	13.3
V.	Indirect	24,383	9,865	40.5
	Totals:	$ 453,986	$ 110,000	24.2%

* Indirect costs are applicable only to DHHS and CDE fund sources. Indirect costs are not collected from other sources, donated dental fees, and LEA contributions.

MIGRANT EDUCATION HEALTH PROGRAM

Percentage of Program
Contribution by Source
-1988-



APPENDIX ITEM # 1

JOB DESCRIPTIONS:

A. Migrant Education Nurse

B. Migrant Nutritionist

C. Migrant Education Dental Hygienist

D. Migrant Education School Health Aide

E. Migrant Education Nursing Student

F. Migrant Education Dental Hygiene Student

G. Migrant Education Dental Student/Resident

JOB DESCRIPTION
MIGRANT EDUCATION NURSE

The Migrant Education (summer school) nurse is responsible for provision of comprehensive nursing services to students as well as coordination of all health activities within her/his assigned school site.

1. Supervises and participates in providing the following health screening services in the Migrant Education school and coordinates the documentation of this data on each child's medical record and MSRTS Health Data Entry Form:

   a. height
   b. weight
   c. hematocrit
   d. scoliosis
   e. vision
   f. hearing
   g. skin test for TB
   h. dental
   i. blood pressure

2. Assesses immunization status of preschool age children and interstate migrants and coordinates the administration of appropriate interstate migrant immunizations (D.P.T., D.T., polio, measles, mumps, rubella) according to the Migrant Health Immunization Policy, and regulations of informed consent.

3. Coordinates and monitors the provision of health services to Migrant Education school children.

4. Provides health assessment and nursing care for children with acute or chronic health problems.

5. Refers children, as needed, for treatment and follow-up services using migrant health authorizations for medical/dental care and pharmaceutical.

6. Coordinates rescreening when indicated.

7. Provides and coordinates follow-up care to the migrant child; informs and involves family members in child's health care by conducting home visits as needed; identify health needs of family members and provide referral services.

8. Institutes measures for the prevention and control of communicable diseases.

9. Provides health conferences/counseling to school personnel, parents and children.

10. Offers consultation to the classroom teachers who are utilizing MSS-HEC (health education curriculum) materials.

11. Coordinates health activities and/or screenings for family nights.

12. Maintains records of activities and services rendered as required by the Colorado Department of Health and Department of Education.

13. Assists in training and supervision of School Health Aides.

14. Supervises nursing student or child health associate student where appropriate.

15. Coordinates and assists in adult clinics where appropriate.

16. Provides health services to migrant school teen programs where applicable.

17. Communicates all health schedules and program activities to the principal and staff as directed by the principal.

18. Provides list of students, health care provided, and needed follow-up to principal, local contact worker and/or regular school nurse.

QUALIFICATIONS:

Must be a Registered Nurse. Prefer nurses with bachelor's or master's degree in nursing although relevant experience (e.g., school health, public health, pediatric nursing) may substitute for this. Spanish speaking ability highly desirable. Must have a car and be willing to work some evenings.

JOB DESCRIPTION
MIGRANT NUTRITIONIST

The Migrant Nutritionist shall be responsible for providing nutrition services to farmworkers (and their families) in specified geographical areas.

Specific duties shall include the following:

The nutritionist's involvement within the school will be coordinated through the school nurse and the school principal.

1. Participates in scheduled screenings with other team members. Assists in recording nutrition related screening data, if available.

2. Provides consultation and follow-up on all identified nutrition problems, as per written protocols.

3. Communicates nutrition care plan through written record in the student medical record.

4. Provides teaching staff inservice training on request.

5. Provides nutrition education in the classroom, on a limited basis, upon request of the principal/teacher. The purpose is to serve as a teaching model for teachers and aides and present means of incorporating nutrition content into the school's curriculum.

6. Participates in "family nights". Special emphasis will be placed on nutrition activities to educate parents in basic nutrition principles and to link classroom activities to the home environment.

QUALIFICATIONS:

Bachelors Degree in nutrition or a related field. Masters Degree or registration with the Commission on Dietetic Registration preferred. Spanish speaking ability is highly desirable. Must have a car and be willing to work some evenings.

JOB DESCRIPTION
MIGRANT EDUCATION DENTAL HYGIENIST

The Migrant Education Dental Hygienist acts as the dental team leader for her/his assigned area and coordinates activities of dental students and dental aides to assure that local dental program objectives are met.

1. Provides dental screening as often as population increases and time constraints allow.

2. Assures communication between nurses/site staff and dental residents and students for dental treatment scheduling.

3. Provides dental health inservice training programs for site staff. Inservices should be tailored to needs and interests of staff.

4. Assists the teachers in implementing dental health education units in the classroom.

5. Provides sealants, dental prophylaxis and topical fluoride applications utilizing portable equipment. Services provided to as many children as time allows.

6. Participates in family nights. Activities may include dental screening for adults, referral, discussion with parents of child's dental health, dental displays, dental plays put on by the children etc.

7. Makes home visits to inform parents of children's dental problems and to assess dental health of family.

8. Completes patient records, MSRTS health record and other forms and data required by the Migrant Education Program.

9. Evaluates program and all materials at end of summer school program.

10. Participates in training and utilization of dental aides when available.

11. Actively participates in all team meetings.

12. Provides inservices training to other health team members.

13. Assures mechanism for interdisciplinary team referrals and follow-up.

QUALIFICATIONS:

Graduated from an accredited Dental Hygiene Program, licensed in a state, eligible for licensure or reciprocity in Colorado. Community health and/or school health experience desirable. Spanish language skills preferred. Must have a car and be available to work some evenings.

JOB DESCRIPTION
SCHOOL HEALTH AIDE

Works under the supervision of health team members (nurse, nutritionist, dental hygienist, dental student). Coordinates activities with other health team members, recruiter and records clerk.

Depending upon the individual needs of a school, the health aide may do some or all of the following activities. (Individualized aide job descriptions will be given to each local Migrant Education Program Director.)

1. Screening

   a) Assists in screening procedures by managing student flow to and from classroom through screening process (i.e., keeping children in line and in proper station).

   b) Assists in record keeping before and during the screening and rescreening as assigned by nurse, nutritionist or dental team member (i.e., identifying information on patient encounter form, recording results of screening procedures as instructed).

   c) Assists in writing follow-up letters to parents.

2. Translation (oral)

   a) Provides translation for non-Spanish speaking health team members.

   b) Provides translation on home visits for health team members.

   c) Provides translation for local providers (physicians, dentists, hospital staff).

3. Transportation

   a) Provides transportation for medical/dental appointments as assigned by the nurse and dental hygienist. This includes:

      1. Responsibility for overseeing children at the medical/dental offices.

      2. Informing the principal of time scheduled for medical/dental appointments.

      3. Responsibility for notifying teachers and nurse of who is scheduled for appointments.

      4. Collecting children to take to medical/dental appointments and seeing that they are returned to school activities after appointments.

5. Acting as liaison between medical/dental office and nurse/teacher regarding possible complications following medical/dental procedures.

6. Responsibility for informing principal and nurse of information from dental/medical offices in order to update school master list daily of children scheduled for medical/dental care. (For example removes a child's name from the list after treatment is completed.)

7. Coordinating exchange of information between nurse, dental students and parents.

8. Acting as liaison between parents and health care provider.

9. Providing assistance as needed with medical or dental procedures.

4. Assists in classroom health education including dental and nutrition.

5. Assists in follow-up care of children. This includes:

   a) Making visits as assigned by principal/director/nurse.

   b) Translating instructions to parents, to the extent possible.

   c) Providing information to parents, to the extent possible.

   d) Completing list of scheduled medical and dental appointments and delivering to concerned parties (i.e., teachers, principal, etc.).

6. Assists in record keeping including medical, dental and nutrition.

   a) Assists in completion of I.D. information on the MSRTS record as assigned by nurse.

   b) Assists in completing non-medical information in patient charts and filing as assigned by nurse.

7. Assists the nutritionist, including:

   a) Plotting height-weight grids.

   b) Identifying lists of children with abnormal nutrition screening results.

8. Assisting the dental hygienist, including:

   a) Assisting the hygienist in dental prophylaxis and fluoride applications.

   b) Supervising daily toothbrushing.

9. Other duties as assigned.

QUALIFICATIONS:

Must be bilingual. Must be able to provide translation services at the school site and accompany school health personnel on home visits. Must be able to maintain confidentiality with health records and health information.

COLORADO MIGRANT HEALTH PROGRAM
JOB DESCRIPTION
NURSING STUDENT

Undergraduate nursing students will be responsible to a designated registered nurse on the health team. Supervision will be jointly shared by this registered nurse preceptor, The Migrant Education Nurse Coordinator, and the school of nursing field faculty. (The registered nurse preceptor of the health team is, in turn, responsible to the Colorado Migrant Health Program Nursing Coordinator for professional issues, and to the Migrant Education school principal for programatic issues.)

1. Assists in the comprehensive health screening of migrant summer school children. This screening includes, depending upon age, anthropometry measurements (height, weight, head circumference), hematocrit, blood pressure, scoliosis check, vision, hearing, and dental screening.

2. Assists in the assessment and, as needed, completion of immunization status of children in the migrant summer school.

3. Assists in the coordination of referrals of identified acute or chronic problems, utilizing appropriate community or state agencies.

4. Provides follow-up care as coordinated with the health team, including home visits.

5. Assists in planning and conducting health education and health screening programs in school and in the community for school family nights, school health nights, community health fairs, etc.

6. Assists, as coordinated with migrant area/contract staff, in adult evening clinics or other adult health services, depending upon setting.

7. Assists in the provision of health assessment, health education, and referral to providers as indicated for migrant children under five years old in 1) migrant daycare/Headstart programs if applicable, or 2) via home visits.

8. Cooperates with health team members, local preceptors, and community agencies to gather necessary data and to maintain records of services and activities rendered in an understandable, concise, legible form, as required by the Colorado Migrant Health Program.

9. Participates in continuous health team development with other team members.

QUALIFICATIONS:

Must be currently enrolled in an accredited nursing school. Must have demonstrated a high level of competence in previous clinical rotations. Spanish speaking ability highly desirable. Must have a car and be willing to work some evenings.

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COLORADO MIGRANT HEALTH PROGRAM
JOB DESCRIPTION
DENTAL HYGIENE STUDENT

Undergraduate dental hygiene students will be responsible to a designated registered dental hygienist on the local team. The designated dental hygienist is in turn responsible to Migrant Dental Coordinator, Mrs. Gretchen Winter.

1. Assists in the comprehensive health screening of migrant school children and preschool children as assigned by the local team. Besides dental screening, may be trained in and provide height, weight, head circumference, blood pressure, scoliosis, vision, and hearing screenings. Assists team, primarily dental team, in completion of forms following screening.

2. As assigned, provides appropriate dental health education sessions in classrooms, to teachers and staff and to other health team members including training of health aides. Acts as a resource to teaching staff.

3. Assists in the completion and updating of dental forms including those related to special studies. (Preventive Planning Form, PNP survey, sealant cards, dental authorizations, etc.)

4. Assists hygienists (and/or dental resident/student) in placement of sealants.

5. Provides, upon negotiation, chairside assisting with the dental students/graduates.

6. Provides toothbrush and rubber cup prophylaxis.

7. Participates in parent activities including family nights and home visits.

8. Participates in scheduled evening adult clinics and treatment clinics in local dental offices/clinics. Provides chairside assisting as needed.

9. Assists in management of treatment appointments.

10. Provides individual patient counseling for children and adults.

11. Participates in continuous health team development with other team members.

12. Assists in completion of all patient and program records at the end of the program.

13. Responsible to same practice act as a dental assistant.

QUALIFICATIONS:

Must be currently enrolled in an accredited Dental Hygiene Program. Community health and/or school health experience desirable. Spanish language skills preferred. Must have a car and be available to work some evenings.

JOB DESCRIPTION
MIGRANT EDUCATION DENTAL STUDENTS/DENTAL RESIDENTS

Migrant Education Dental Students work under the direction and (most often) in the offices of local dentists who serve as their preceptors.

1. Immediately following screening, sets dental treatment priorities and schedules for each child with identified dental needs.

2. Re-prioritizes treatment schedules every week.

3. Directly coordinates with Migrant Education nurse all treatment scheduling.

4. Provides training and supervision of assigned aides.

5. Notifies parents of dental treatment for their children before it is given through informed consent form and/or home visits.
6. Completes all records and forms on a timely basis.

7. Provides inservice training for Migrant Education staff upon request.

8. In conjunction with dental hygienist, screens all enrollees of Migrant Education schools and provides referral services.

9. In conjunction with dental hygienist, provides education programs for enrollees of Migrant Education schools.

10. In conjunction with other team members, provides home visits and consultations to parents who have children with a high incidence of caries identified during the dental screening process.

11. Participates in family night presentation about dental health to parents of school children.

12. Attends all health team meetings and extended health team meetings. (Local health department, preceptor, migrant nurses, etc.)

13. Provides dental information to team members and provides education tools whereby team can easily communicate dental information to patients.

14. Plans and conducts inservice training sessions on dental etiology, pathology, and screening techniques for the interdisciplinary team in the area.

QUALIFICATIONS:

Dental Student

Currently enrolled in an accredited dental school in the States with a minimum of three years completed. Must receive the recommendation of school faculty and be acceptable to the University of Colorado Dental School. Pedodontic experience essential. Spanish speaking ability desirable. Must have a car and be available to work some evenings.

Dental Resident

Must be a graduate of the University of Colorado School of Dentistry and currently enrolled in the ACTS program or comparable program that is acceptable to the University of Colorado School of Dentistry. Must be eligible for licensure in Colorado or currently licensed in Colorado. Pedodontic experience essential. Spanish speaking ability desirable. Must have a car and be available to work some evenings.